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# ***Canadian Hospital***

- *Medical Challenge to  
the Social Sciences*
- *Cours, jolie courroie*
- *A Helping Hand to Children*
- *Regional Hospital Co-ordination*
- *Canada Looks North to Uranium City*
- *Disaster Institute Held at Windsor, Ont.*



***Canadian Hospital Association***



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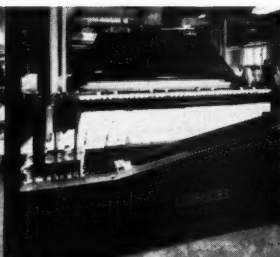
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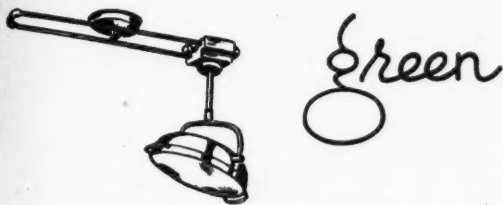
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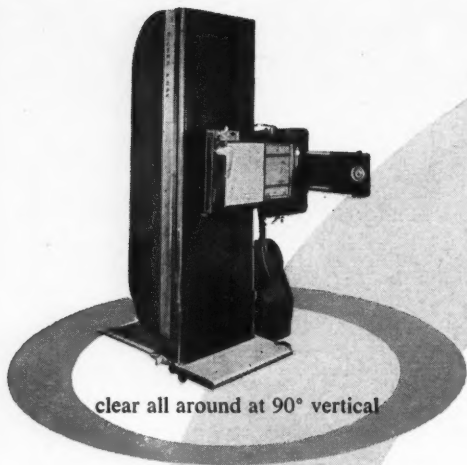
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CANADIAN HOSPITALS FROM COAST-TO-COAST

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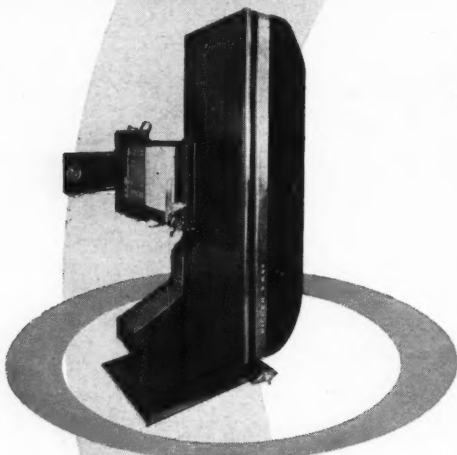
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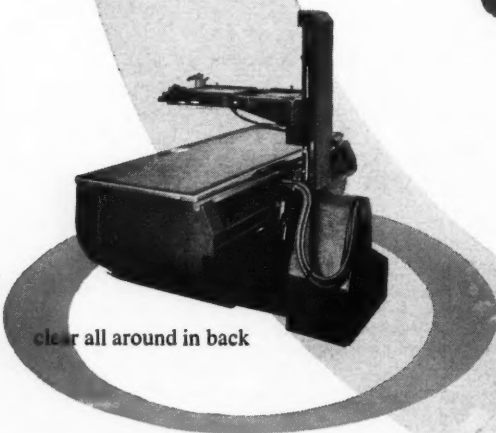
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clear all around at 90° vertical



clear all around at 90° Trendelenburg



clear all around in back



clear all around in front

## clear all around

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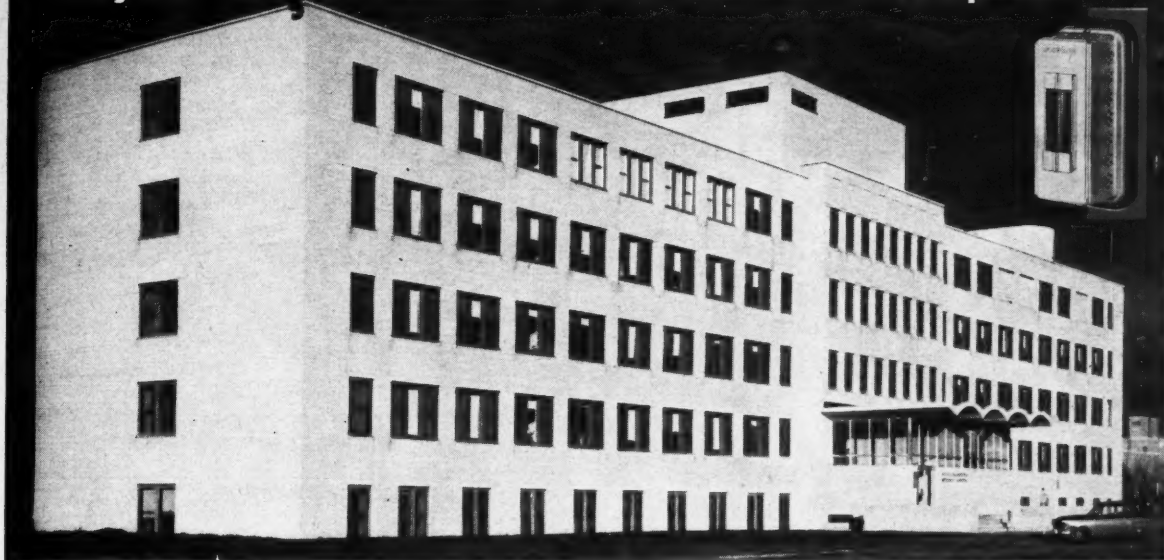
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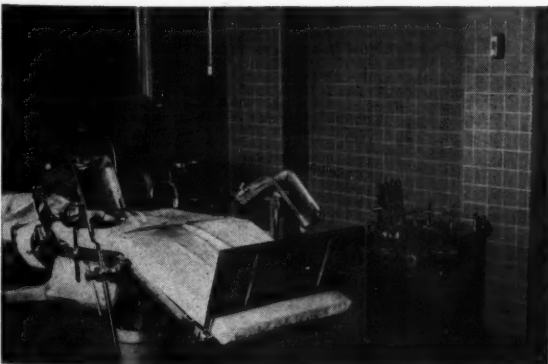
You can also be sure of satisfying the most exacting hospital safety requirements. Pneumatically operated Johnson Control is *completely safe, even in the presence of explosive anesthetic gases!* In addition, Johnson Humidity Control gives important protection against the dangers of static electricity.

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\*Royal Alexandria Maternity Hospital, Edmonton, Alberta. Rule, Wynn & Rule, architects; Angus Butler & Associates, Ltd., mechanical engineers; Carse Anderson, Ltd., mechanical contractor; all of Edmonton.

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## ◀ Notes About People ▶

### E. V. Walshaw, a Director Canadian Hospital Association

(This is the 12th and final in a series of biographical notes, introducing officers and directors of the Canadian Hospital Association for 1955-57.)

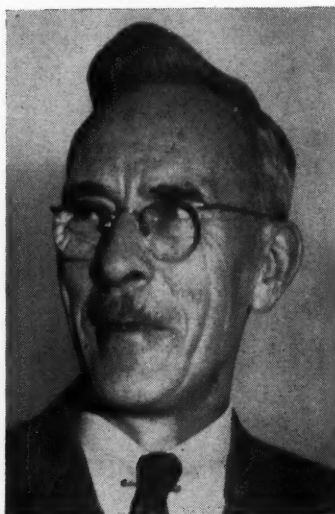
E. V. Walshaw was appointed to the Board of Directors of the Canadian Hospital Association at the 1955 biennial meeting, held in Ottawa, and is a member of the Committee on Constitution. Since 1953 he has been executive secretary-treasurer of the Saskatchewan Hospital Association.

Mr. Walshaw knows hospitals from long practical association. In 28 years of service with the Saskatoon City Hospital, he has held the positions of house steward, purchasing agent, administrative assistant, assistant superintendent, and acting superintendent. These years of continuous service with one hospital were broken only on one occasion. During World War II, Mr. Walshaw was granted leave of absence to serve with the Saskatoon Light Infantry.

His many years of association in various positions in the Saskatoon City Hospital have given Mr. Walshaw a unique hospital experience which he now uses to advantage for the benefit of all the hospitals of Saskatchewan.

Educated in a public school at Sunderland, England, he served with the Royal Garrison Artillery overseas and was wounded at Arras in 1916. In 1924 he came to Canada with the intention of settling in British Columbia. On his journey west he fell in love with the prairies and has made Saskatoon his home ever since, apart from military duty during World War II. It was during the period he was acting superintendent of the Saskatoon City Hospital that he was associated with the first television broadcast to be made in Canada. This was a closed circuit broadcast of surgical operations from the City Hospital to the Bessborough Hotel arranged by the Canadian Medical Association and a pharmaceutical firm. This occurred while a meeting of the Canadian Medical Association was taking place.

Mr. Walshaw is well known in Saskatchewan where he has a host of friends. He has a natural ability to get along well with all kinds of people who respect him for his personal integrity,



E. V. Walshaw

conscientiousness, friendliness, and helpfulness. By his close friends he is referred to as "Wally". While he does not appear to act under pressure he is capable of prolonged concentration and has been known to work for 18 hours at a time. Artistic in nature, he has on occasion in the past painted murals for the tea room and children's ward of the Saskatoon City Hospital.

Mr. Walshaw is the first full-time secretary of the Saskatchewan Hospitals Association. His position takes him to all parts of the province and it is his objective to visit each hospital in the association at least once every two years. From his practical hospital experience he is able to offer assistance on many day-to-day hospital problems.

### Dr. L. B. Pett in Rome

Last month, Dr. L. B. Pett, Chief, Nutrition Division, Department of National Health and Welfare, journeyed to Rome for a ten-day United Nations calorie conference. There he met with ten nutrition experts from six different countries to discuss calorie requirements. Dr. Pett was the only public health nutritionist present, the others being authorities on nutrition research. His advice was sought as the person responsible for the Canadian Height-Weight Survey — which provides

data related to obesity not found elsewhere. He also advised on the practical application of nutrition, a subject basic to the objective of better feeding throughout the world.

A native of Winnipeg, Dr. Pett served as advisor to the Canadian delegation at the first session of the Food and Agriculture Organization in 1945 and at subsequent meetings. Besides being head of the Nutrition Division at Ottawa, he is chairman of the Canadian Council on Nutrition and serves as nutrition advisor to various branches of the federal government.

### Dr. R. M. Wansbrough

A man who devoted half his lifetime to mending the bodies of children died on May 24th, in Toronto, Ont. Robert Marshall (Tim) Wansbrough, M.D., F.R.C.P.S.(C), surgeon-in-chief at the Hospital for Sick Children, served on the staff of that hospital for 28 years, except during the war when he was overseas. Born in Grand Valley in 1900, Dr. Wansbrough received his medical training at the University of Toronto, and was graduated in 1924. He went to Cleveland for postgraduate work, and married Eugenia Pearl Chadwick of that city in 1927. His internship was served with the Hospital for Sick Children. The honorary chairman of the hospital board said in tribute to Dr. Wansbrough: "He did wonderful work for the children of the city and the province, and was highly regarded by everyone."

### From Victoria to Edmonton

The dynamic medical superintendent of St. Joseph's Hospital in Victoria, B.C., Dr. A. J. Brunet, will leave that post to go to Misericordia Hospital in Edmonton at the end of September, it is announced. He has been in Victoria for the past three years.

A native of Montreal, Dr. Brunet served for six years with the R.C.-A.M.C. during World War II. On his return he joined the Department of Veterans' Affairs and later acted as a field surveyor for the American College of Surgeons which then conducted what has come to be known as the accreditation program. In this latter capacity, he travelled across Canada and inspected some 500 hospitals.

### Overseas Visitors

Recent overseas visitors to the Association office have been Frank Hart, secretary, Charing Cross Hospital, London, England; Edmond W. Grace, chief executive officer and secretary of St. Vincent's Hospital, Melbourne, (Continued on page 16)

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— USED MORE IN CANADIAN HOSPITALS  
THAN ALL OTHER BRANDS COMBINED

## Notes About People

(Continued from page 12)

Australia; and Mr. A. R. W. Bavin of the Ministry of Health of Great Britain. Mr. Grace, as honorary secretary of Victoria Hospital Association, was primarily interested in the extension courses, our hospital journal, and the *Canadian Hospital Accounting Manual* now under revision. Mr. Bavin was interested in methods of payments to Canadian hospitals and in the accounting manual. The visit of all three to our office was part of their itineraries which included various hospitals, hospital associations, and government departments in Canada and, the United States.

### Appointments to Ontario Cancer Institute

At the new Ontario Cancer Institute which is adjacent to the Wellesley Division of Toronto General Hospital, four key appointments have been announced. Dr. C. L. Ash, director and professor of therapeutic radiology, University of Toronto, is a fellow of the American College of Radiology. Dr. O. H. Warwick, senior physician, is consulting physician to the Ontario Institute of Radiotherapy and is a rep-

resentative on the International Cancer Research Commission. Dr. A. W. Ham, who has been a member of the research advisory group of the National Cancer Institute, heads the division of biological research. Dr. H. E. Johns, chief physicist, is president of the Canadian Association of Medical Physicists and a director of the National Cancer Institute of Canada.

### Paul Martin Honoured

At its spring convocation last month McGill University, Montreal, conferred upon Hon. Paul Martin, Minister of National Health and Welfare, an honorary doctorate of laws. This month, the University of Montreal has conferred the same degree upon Mr. Martin.

### Visitor from I.C.N.

Daisy C. Bridges, executive secretary of the International Council of Nurses, with headquarters in London, Eng., officiated at the laying of the corner-stone for the new offices of the Registered Nurses Association in Toronto last month. From there she went on to address the biennial meeting of the American Nurses Association in Chicago.

Miss Bridges is a graduate of the

Nightingale School of Nursing at St. Thomas' Hospital, London, a school from which nurses have gone to all parts of the world to help establish other schools. Her visit to Toronto happily coincided with the birthday of Florence Nightingale which is observed as National Hospital Day.

### Temporary Administrator

Dr. Pearl Hopgood, Dartmouth, N.S., retired assistant superintendent of Nova Scotia Hospital in Halifax, has been appointed administrator of Cape Breton County Hospital on a temporary basis. One of Canada's outstanding women psychiatrists, Dr. Hopgood agreed to accept the post, pending the results of an investigation to which the hospital is subject.

### To World Health Assembly

Canada has been elected to the executive board of the World Health Assembly, the governing board of the World Health Organization. The Assembly elects six countries to its 18-member board each year and each serves for a period of three years.

Heading Canada's delegation to the WHO assembly is Dr. G. D. W. Cam-

(Continued on page 20)



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## Notes About People

(Concluded from page 16)

eron, Deputy Minister of National Health and Welfare, who is also Canada's member at the 18th session of the Executive Board.

Among other members of the Canadian delegation to the Assembly are Dr. F. Burns Roth, Deputy Minister of Public Health for Saskatchewan; Dr. Emile Blain, director-general of the Canadian Association of French-Speaking Doctors; and Dorothy M. Percy, chief nursing consultant, Department of National Health and Welfare, Ottawa.

### Back to University

Nora Coleberry, superintendent of Haldimand War Memorial Hospital at Dunnville, Ont., has tendered her resignation, effective August 31st. Miss Coleberry is returning to university to complete her course for the degree of bachelor of nursing, her resignation having been accepted with regret.

### Plummer Medal

Dr. Morris Katz, atmospheric pollution expert, Occupational Health Division, Department of National Health and Welfare, Ottawa, has been awarded the Plummer Medal by the Engin-

earing Institute of Canada. The medal is awarded annually for outstanding achievement by a Canadian engineer.

Before accepting his present post in January of this year, Dr. Katz had been on the staff of the Defence Research Board as a research scientist for seven years. He is chairman of the Canadian section of the Technical Advisory Board on Air Pollution to the International Joint Commission.

- Dr. Gordon Murray of Toronto, well-known heart surgeon, is the fifth recipient of the Beth Shalom Brotherhood Award for humanitarian work.

- At the annual meeting of Niagara Hospital, Niagara-on-the-Lake, Ont., W. H. Hunter was elected chairman of the board of directors, with M. T. Henry as vice-chairman.

- Dr. Joseph C. C. Dawson of Peterborough was elected president of the Ontario Medical Association at its annual meeting last month. He succeeds Dr. M. O. Klotz of Ottawa.

- Last month the University of Toronto conferred upon E. Kathleen Russell, director emeritus of the university's school of nursing, an honorary doctor of laws degree.

- At the annual meeting of the hospital trust of Welland County General Hospital, James F. Swaze was named chairman of the board.

- Robert T. Evans, executive director, Blue Cross Plan for Hospital Care, Chicago, has been elected chairman of the Blue Cross Commission of the American Hospital Association. The latter body is the co-ordinating agency for the 86 Blue Cross plans on this continent.

- Bernard Nantel, Montreal, has been elected a life governor of Hôpital Notre Dame in that city, according to an announcement by Dr. Paul Bourgeois, director general of the hospital.

- J. E. Smith, chief pharmacist at Royal Jubilee Hospital, Victoria, B.C., was recently presented with a gold pin in recognition of over 25 years of service with that hospital.

- Members of the staff of Brandon Hospital for Mental Diseases, Brandon, Man., gathered to pay honour to Bill Bevis on his retirement after 14 years of service. Mr. Bevis was head of the piggery.

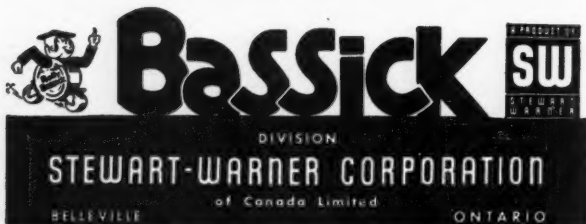


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## Obiter Dicta

### *The Ontario Hospital Services Commission*

THE announcement by Premier Frost on Friday, May 11th, that A. J. Swanson had been appointed chairman of the Ontario Hospital Services Commission has been received as welcome news, not only by the hospitals of his own province but generally throughout Canada. It is gratifying that a man with such a broad personal knowledge of hospital affairs has been appointed to head this important commission. With 30 years' experience at the Toronto Western, with his long and extensive service with the Ontario Hospital Association, and in the national and international hospital fields, A. J. Swanson is exceptionally well qualified to head this important body.

It is good news, too, that the commissioners also have a wide understanding of hospitals. Monsignor John G. Fullerton has been associated with St. Joseph's Hospital, Toronto, the Ontario Hospital Association, the Canadian Hospital Association, and the Catholic Hospital Association of Canada. He will bring to the commission a keen appreciation of Sisters' hospitals, which play such a large and important part in patient care, and also a deep insight into the hospital problems of Ontario and of Canada. Dr. J. B. Neilson, as the administrator of one of Canada's largest hospitals, the Hamilton General, is a member of the board of directors of the Ontario Hospital Association and of the Canadian Hospital Association. He has an intimate day-to-day familiarity with all hospital matters.

Undoubtedly the main reason for the appointment, initially, of three hospital people to a seven-man commission is that the commission's main task in the early stages will be to review the hospital picture as it now exists in Ontario. From there, it will move on to planning for the further extension of hospital services and possibly for the inauguration of a form of hospital insurance. It is noteworthy that all three have an intimate knowledge of the operation of the Ontario Hospital Association's Blue Cross plan. This plan has had a phenomenal growth. Starting in 1941, it now has over 2,000,000 subscribers. In working to extend the coverage of hospital insurance to all of Ontario's population, the knowledge which these commissioners already possess should prove invaluable.

All hospital people wish Mr. Swanson, Monsignor Fullerton, and Dr. Neilson every success in their new posts. Any province-wide plan of hospital insurance has many in-

herent problems — financial, economic, geographic, and administrative, to mention a few. Of paramount importance is the welfare of the public and the hospitals. The members of the Ontario Hospital Services Commission are in a position, from first-hand knowledge and practical experience, to know the extent of the many factors involved and to work toward satisfactory solutions.

### *Sufficient Personnel the Key*

A TOPIC which during recent discussions of national hospital insurance, has not received the study it merits, is the question of the availability of sufficient hospital personnel for any expansion of services. During World War II and for some years thereafter, one could not read a hospital journal without finding some reference to staff shortages. Recently very little has been said and there may be a widespread opinion that staff levels now are satisfactory. A closer examination, however, will indicate that at present shortages are quite apparent. This is particularly true of female personnel, especially as it relates to professional and technical groups.

Throughout Canada there is a general shortage in most groups of female workers. There are simply not enough young women available for the various industrial and professional fields each year. The reason is, there were not enough of them born during the depression years to fill all the positions now open. Students of census statistics state that this situation will not be rectified until some time after 1960. One factor, however, has eased the situation, *i.e.* times have changed; and many married women are working today who would not have been available to the general work pool in an earlier period. In the vital department of nursing service it has been the large number of married nurses who are working on a part-time basis and the new group of nursing assistants who have made it possible for hospitals to provide a satisfactory level of nursing care.

Today a young woman leaving high school has many opportunities. Every sphere that she might consider as her possible vocation in life is short of personnel. Whether she decides to become a nurse, a dietitian, a medical record librarian, a physiotherapist, a laboratory or x-ray technician, a teacher, or a stenographer, many positions

are open to her. This being so, she is bound to consider carefully the length of any particular course of instruction, the cost involved, and the remuneration she will receive when she enters her particular field. With things as they are, and as they undoubtedly will continue to be for some time, can anyone blame a young woman for choosing a vocation requiring less preparation, particularly when she can start earning two to three years earlier? For example, a stenographer today in parts of Canada can start at about the same salary level as a general duty nurse who has had to take three years of training. It remains true, however, that many young women are willing to defer their earning power for three years while they devote themselves to study in preparation for a nursing career. Admittedly, nursing has a wide appeal for young people and the spirit of service is a strong factor with many. One must not over-emphasize these points, however, and forget that there is real competition among various groups for today's high school graduates.

So far, we have mentioned shortages among female groups. One does not wish to infer that there are no shortages among male hospital workers. There is a noticeable scarcity of pharmacists and interns. While neither of these two professions is exclusively the domain of the male, men form the majority.

Another factor is the continuing tendency for a shorter work week. It is not so long ago that the 48-hour week was quite standard throughout the hospital field. Today in one province the 40-hour week is standard practice; in an adjoining province several hospitals are also on a 40-hour week; and in many other areas the 44-hour week is the longest for any hospital worker. Even if no additional hospital beds were being constructed, the shortening of the work week will demand more personnel. New hospital beds, however, are being opened continually and each time a new hospital opens its doors much of the staff has to be recruited from existing hospitals. As many of these new hospitals are situated in communities distant from large centres, to attract workers they have to offer either a higher wage schedule or some perquisite to entice employees from other positions. This, from an economic point of view, is like a cat chasing its tail, because sooner or later the reaction of the large centres is to increase their schedules to hold their own staffs.

From the point of view of the professions within the hospital seeking to augment the numbers entering their own ranks, there has to be a continuing review as to how their scale of remuneration stands in comparison with other groups in the community. Those charged with the administration of hospitals during the personnel shortages of the war years will remember how we told ourselves frequently that when the war was over things would be different, our shortages would disappear, and day-to-day administration would be ever so much easier. Looking back, it is probably just as well that we could not foresee all the difficulties which were to be encountered.

It is not our intention in this editorial to adopt a complaining note; we as Canadians should be very proud that our country is expanding at such a rapid rate. In hospital administration we must be certain that we are not attempting to operate in 1956 with a philosophy based on the 1930's. In those days work was scarce, new jobs were hard to find and, if one held a position and did not like the work, one had to think of financial security and the difficulty of finding another. How different things are today!

A short time ago a leading hospital administrator said that national hospital insurance was impossible within the next five years. The reason given — there was not sufficient personnel to make it possible on a national scale. This may be an overstatement. However, one thing is ap-

parent — we must not overlook the question of adequate hospital personnel and, in a buoyant economy, there is bound to be competition for the people available.

From all of this, at least from the point of view of this writer, one thing is certain. Hospital costs, which have been steadily rising over the past few years, are going to increase further. In estimating the total cost of national hospital insurance, full allowance must be made for this fact.

## Two Books Well Worth Reading

TWO books have been published recently in Canada which merit the special attention of all concerned with hospital administration. Both are readable and factual; both help to fill a need for information on their respective subjects.

Professor Malcolm Taylor's book, *Health Insurance in Canada*, has been reviewed in *The Canadian Hospital* (see May issue, page 82). The subject of health insurance, particularly hospital insurance, is very much in the news and anyone in an administrative post in a hospital needs to keep informed on what has transpired. Because there are many voluntary and government-sponsored forms of hospital insurance, with differences in operation, it is not easy to form a clear picture of current developments in this field in Canada. Mr. Taylor's book does just this for the reader. Anyone who reads these 270 printed pages is sure to gain a much improved understanding of health insurance as it now exists in our country.

Dean Meredith's book, *Malpractice Liability of Doctors and Hospitals*, is reviewed in this issue on page 64. We know from practical experience, at Canadian Hospital Association headquarters, that there has been a widespread need for a book on this subject. It is not the intention of the author to make lawyers out of hospital administrators — because it is equally dangerous for a hospital to be its own lawyer as it is for a patient to be his own physician. Every hospital board should have a solicitor to whom they turn regularly for legal advice. However, every hospital administrator should be familiar with general principles relating to the liability of hospitals and of individual staff members. This book, in addition to clarifying many points that have troubled hospital people, will create an increasing awareness of legal responsibilities in relation to patient care.

A notable feature of these two books is that they are written by Canadian authors, primarily for Canadians. To date, much of our hospital literature in book form has originated in the United States or Great Britain. Although hospital administration is much the same in all three countries, there are differences in geography, economics, and law which have to be taken into account when applying American and English data to Canada. *Health Insurance in Canada* and *Malpractice Liability of Doctors and Hospitals* are two Canadian books we would like to see in every hospital library and read by all hospital administrators.

## 1956 H.O.M. Summer Sessions

At Huron College, the University of Western Ontario, London, Ont., this month, there are 125 senior hospital personnel from all parts of Canada engaged in the summer session of the extension course in hospital organization and management. These include first and second year students. They all attend certain combined sessions but, for most lectures, are separated by year, with amplification of the

subjects studied in the winter session and a concentration on those which are difficult to assimilate by the written word alone. In the second year, each student is responsible for a seminar presentation and for leading a discussion period as well.

This session provides an opportunity for administrative personnel to escape the pressure of daily demands in their own hospitals and concentrate solely upon broadening their approach to organizational methods and management techniques. Lectures are being given by authorities in the hospital field in Canada and the United States; medical staff, university professors, hospital administrators, senior department heads, and business men, are speaking on specific topics upon which they are considered to be expert. Field visits are made to local hospitals; and there is ample opportunity for informal discussion both in and out of the classrooms. The atmosphere in London is pleasant; the university is situated among green fields outside the city limits. Here the temptations of urban activity are reduced and there is time to organize your thoughts for long-range planning.

It is difficult to estimate the value of a four-week study period. If the program is stimulating and the class members are intelligent and eager, the measurement of work becomes an individual matter. Discussion of new and old ideas in hospital organization and management provides stimulus for the development of the participant, and the effect should be felt on his or her institution in the months and years to follow. Ilka Chase once said that "You can spot a well-informed man — his views are the same as yours". This is not good enough for hospital administration. There is plenty of scope for variety in the application of sound administrative principles. Summer sessions and institutes provide the ideal setting for airing these views; and the individual may choose the best method to apply the most sensible solution to problems in his or her own situation. It is sincerely hoped that the members of the classes in London will both enjoy and benefit from the 1956 summer session. — R. J. M.

### L'Annuaire des Hôpitaux Canadiens

L'EDITION 1956 de l'Annuaire des Hôpitaux Canadiens est maintenant disponible au public. Publié chaque année depuis 1953, l'édition courante comprend toutes les sections inclues l'année dernière, et aussi une section additionnelle au sujet de l'accréditation de l'hôpital. Cette division-ci doit être d'une grande valeur à l'administrateur, au gouverneur d'hôpital, au chef du personnel, et aux autres qui s'intéressent aux détails d'accréditation, puisqu'elle contient des données explicatives et des formules d'inspection récemment révisées par la Commission Collective pour l'Accréditation des Hôpitaux. On a gardé les renseignements concernant le service de bibliothèque fourni par l'Association des Hôpitaux du Canada, et les sources d'aides visuels (ce qui était publié pour la première fois dans l'annuaire de 1955); mais la liste des livres disponibles et la liste représentative des films ne paraissent pas cette année. Les nouveaux livres acquis pour la bibliothèque seront mentionnés de temps en temps dans *The Canadian Hospital*.

Des tables indiquant le nombre d'hôpitaux au Canada, le nombre de lits, et des renseignements semblables, sont encore inclues. Ces chiffres ne doivent pas supplanter les statistiques beaucoup plus étendues publiées chaque année par le Bureau Fédéral de Statistique sous le titre *Statistiques des Hôpitaux — Volume 1*. Toute personne s'intéressant à l'étude de statistiques sur le plan national devrait employer les rapports du Bureau Fédéral de Statistique. Nous

croyons, néanmoins, que les tables inclues dans l'annuaire sont très utiles, et qu'elles fournissent un supplément de grande valeur pour accompagner la statistique officielle. Ceci est dû en partie au fait que ces chiffres sont au courant presque au mois de publication (mai); et aussi que tout hôpital, public, privé, et gouvernemental, est inclu, s'il a envoyé un rapport direct ou non. L'information des tables est fournie principalement par l'hôpital lui-même, suppléée et vérifiée par de nombreuses sources.

Les tables indiquent qu'il y a 1,422 hôpitaux d'une variété de catégories et de grandeurs au Canada, qui comprennent 188,934 lits. Ceux-ci incluent 832 hôpitaux public général avec 79,117 lits; 196 hôpitaux public spécial avec 88,986 lits; 251 hôpitaux privés avec 6,056 lits; et 143 institutions fédérales avec 14,775 lits. Des 188,934 lits enregistrés pour tout le Canada, dans les tables, 84,966 sont classés comme général; 62,586 comme mental; 18,402 pour le soin de tuberculeux; 9,543 pour le soin de malades chroniques. Les autres sont classifiés dans une des catégories suivantes: contagieux, convalescent, orthopédique, divers, infirme, ou domiciliaire.

La table numéro 2 pour le Canada indique clairement que, quant au nombre, la majorité des 1,422 hôpitaux possèdent moins de 50 lits. Il y en a 175 dans la catégorie 1-9 lits; 368 dans 10-24 lits; et 287 dans 25-49 lits — un total de 830 hôpitaux dans les trois premières catégories. Il y en a 190 de 50 à 99 lits; 183 dans 100-199; 64 avec 200-299; 70 ont 300-400 lits; et 85 hôpitaux contiennent 500 lits ou plus. La table 2 donne aussi la distribution par classe et propriété, et indique qu'il y a 547 hôpitaux laïcs, avec 44,307 lits; 338 hôpitaux sous les auspices de religieux, avec 59,563 lits; 293 hôpitaux municipaux avec 19,340 lits; et 244 autres (hôpitaux provinciaux et fédéraux) avec 65,634 lits.

Le rédacteur-en-chef ne prétend pas que ces tables soient infaillibles; ils sont, néanmoins, aussi exactes qu'on a pu les rendre après une interprétation soignée de toutes les données disponibles. Il faut mentionner, cependant, que la distribution des lits selon la sorte des soins reçus devient souvent une question d'opinion. Ceci est surtout le cas dans les catégories, chronique, convalescent, infirme, domiciliaire, et divers.

Le rédacteur croit que, pour raisons administratives, le chiffre des lits qui a le plus de valeur est le nombre de lits dressés. Sauf dans la colonne de la Table 1 intitulée "capacité normale en lits" introduite pour des raisons de comparaison, lits dressés sert, dans les tables. L'expression "dressé" s'explique. L'expression "capacité normale" représente le nombre de lits projeté pour l'hôpital en question. Il est déterminé par des critères établis par les autorités de la santé provinciale et est contrôlé par les minima suivants:

Adultes	— chambre simple	— 100 pieds carrés
	— accommodement multiple	— 80 pieds carrés
Enfants	— chambre simple	— 80 pieds carrés
	— accommodement multiple	— 50 pieds carrés
	— petits enfants (sauf nouveau-nés)	— 30 pieds carrés

Nous voulons profiter de cette occasion pour exprimer notre gratitude à tous ceux qui ont rendu possible la publication de l'Annuaire des Hôpitaux du Canada de l'année 1956. L'assistance d'administrateurs, d'autre personnel d'hôpitaux, exécutifs d'organisations alliées, et d'officiers du gouvernement nous a été d'une valeur incalculable. En effet, on n'aurait pas pu compléter l'annuaire sans leur participation active. L'appui continu de nos annonceurs nous a permis encore une fois de rendre le format attrayant. A tous les intéressés nous sommes reconnaissants

(See page 92)

I HAVE wished for some time to review, and perhaps re-organize, some of our current thinking on the relationship of medicine to the social sciences. We, on the social science side, have been deeply stirred by the challenge that comes to us from the present leadership in modern medicine and, especially, from within the national health agencies and the university medical centres. The challenge has become for many of us something like a "Macedonian call to come over and help". Almost everywhere that we have been able to respond to it, we have been heartened. We have been heartened by the warm reception accorded to us; by the patience and tolerance during our periods of apprenticeship; by the camaraderie and friendly banter leveled at any pretensions on our part; and by the very substantial amounts of co-operation and support provided for us wherever we have found productive projects to pursue.

#### The "Social Sciences"

Perhaps it would be well for me to clear up a possible misunderstanding that may be lodged in the topic itself. I refer to the phrase, "the social sciences".

No high pretensions are implied on my part. It is not inferred, for instance, that the social sciences are strictly comparable to the physical sciences in methodology, techniques, or present achievements. Within the broad framework of the scientific approach and its principles, there is much in common, of course, but the different nature of the subject matter certainly dictates some difference of techniques in investigation and analysis. Moreover, the physical sciences are far ahead in their development.

However, when our joint aims are made clear and kept shining before us, the differences in methodology seem secondary and they may even prove to be complementary. I take it that our joint aims are clear; that they are to gain more complete and dependable knowledge on how to regain or preserve our health. They involve, in other words, a systematic attempt to identify, understand, and manipulate more and more of the important variables in this difficult field.

#### Two Points

Here at the start I would like to make clear two related points. The first one is a personal sense of futility that is felt over the controversy as to whether the social sciences are scientific when measured by all the criteria of the strictly physical sciences.

We are learning, I think; that we can make ourselves appear very foolish by straining to ape the techniques of

## A Medical Challenge to the Social Sciences

### Part I

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the physical sciences in the wrong places. Let us say, for clarification, that if the phrase "the social sciences" proves a stumbling-block to our free communication, then we shall drop its use. We shall resort, instead, to the more cumbersome procedure of naming the several existing disciplines in the field, such as anthropology, sociology, social psychology, economics, political studies, and the like. That is all I mean by the social sciences. The phrase is used as a covering label of convenience for these several disciplines. It stakes out no pretentious claims.

Barring a bad stumble over the first point in semantics, the second point becomes for some of us a much more serious matter. While we are strongly encouraged in the medical challenge that confronts us, and some of us are making long-term shifts in our careers to meet it, we are quite seriously concerned over the bases for our durable and productive collaborations. To be frank, we are fearful that our professional colleagues in the health fields may expect of us much more than we are presently prepared to offer; or, worse still, that we may promise more than we shall be able to deliver on schedule.

It would be most unfortunate for all concerned should our present very promising alliance suffer a set-back on account of unrealistic expectations. We would not imply (and we can ill afford to have it implied) that our so-called social sciences already carry a rich cargo of ready-processed and neatly-packaged contributions to be made to medicine on request or demand.

I sometimes feel very shy when I hear a dean of a medical school or the director of a health project remark: "Well, I am going to get myself a social scientist to come in and set us straight on our problems in social relationships!" He not infrequently adds, as a kind of second thought, "Whom can you recommend?"

Then, if there is a demur on my part, he may ask rather pointedly: "Shall it be an anthropologist, a sociologist, a special psychologist, or what? And, by the way, will you please tell me just what is the difference between these three, and between them and social workers?"

Then I am truly stumped in terms of trying to meet concretely the specifics of his purpose; for whoever is recommended under these expectations is likely to prove an early disappointment. The fact of the matter is that no one of us is in a position to design for medicine any social gadgets on order; or to write out any social science prescriptions on the spot. I repeat, that this second point of unrealistic expectations is a more serious pitfall for us than is the first one; and especially so in our relationships with physicians in the more strictly clinical situations.

Let me illustrate. Early in my apprenticeship in the New York Hospital, a physician said, in effect:

"I know that there are social forces in the communities, and in the families of some of my patients, which are working against all that I can do for them. I know that it is these very forces, more than anything else, that keep them ill or ailing. Tell me how to put my finger on these factors and how to change them."

Such a request should *not* call forth from us a prompt and pat reply.

The comments of another physician, on medical care in the hospital, were:

"There is no need to wait until we have scientific perfection in the social sciences. It would be a great gain if we could receive some more reliable guidance as to what types of action to take in specific situations in the hospital; or, of a number of possible alternatives, which buttons to push in order to make the most of the institutionalized resources in human relations, and to minimize the harmful ones."

That, too, is a long-term order, with many ramifications. In the broader community context, one physician declared:

"The most pressing problem today

in medical education and in determining the requirements of good medical care is an analysis of the position of the doctor in contemporary society. Is not such an analysis necessary before it can be decided what kind of physicians should be turned out?" Well, that looks like a \$32,000 question, at least.

The social sciences do not have at their finger tips any validated answers to such very specific and pertinent problems, and one more guess from us is not what is expected. Let us be humble and honest about it—we are just not in a position to deliver on order such patented products.

We do sincerely hold, however, that the social sciences have come a long, long way in the past few decades; that they carry a significant accumulation of social data; that they have acquired an impressive body of basic concepts; and that they possess, scattered in various contexts, a very substantial number of principles and formulations that may prove eventually to be highly pertinent to the health field. These, of course, have to be assembled, sometimes translated, and not infrequently retested in terms of the medical and health interests. That is an old story, however, in almost every form of inter-disciplinary endeavour. Indeed, it may even turn out that, for some time at least, the social science collaborators will make greater progress when left free to ask their own questions in terms of their backgrounds, skills, and abilities.

When the initial and impractical aspects of the challenge have been cleared up or passed by, we hope to settle down to the more solid premises and possibilities that underpin, and also inspire, our serious and long-term collaborations. And it is my opinion that these are quite different from the expectations described above. I would like to explore a few of them. So far, however, I have been able to do no more than scratch the surface.

From the medical and health side, the matter seems to boil down to this: when the early "windfalls" are in, and accepted or rejected, what durable contributions can the social sciences make to medicine under conscientious and long-term collaboration?

#### Two Major Contributions

On the medical side, two particularly important notions keep occurring to me. The first is the potential place of the social sciences in improving the practice of medicine. The second is the possible role of the social sciences in aiding understanding of the etiology and dynamics of both sickness and health. I hope to expand somewhat

the first notion in this paper and at least carry along the second idea, as an equally important underlying theme.

In my apprenticeship with medicine, for which I am deeply indebted to the Yale School of Medicine and the Cornell Medical Centre, a first and foremost premise for the social sciences has been impressed upon me repeatedly. This premise is that, wherever we look, the more effective medical practice involves and utilizes, in one way or another, something more than the available knowledge provided solely by the physical sciences. Moreover, this something often appears very significant in the light of results obtained.

Indeed, in the broad background of the healing arts, as exemplified in both the medicine man as a prototype, and the horse-and-buggy physi-

hold either his practice or his medical license, if he attempted to perform his medical services solely on the basis of his knowledge of the physical sciences and nothing else.

In any perspective, past or present, then, our exemplary physicians appear to make maximum use of existing knowledge of the physical data concerning a disease; and at the same time, they link up with this knowledge a substantial amount of social knack or "know-how" in dealing with sick people in life situations.

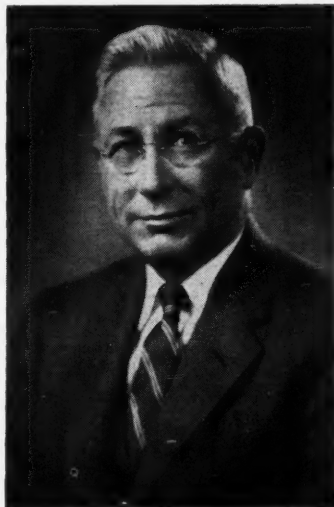
In other words, the "psychosocial stuff", as well as the physical, is always there to be comprehended and manipulated in medical practice. If systematic knowledge of this side of sickness and health is lacking, the therapist of necessity tends to fall back on "common sense" and folk-wisdom as a substitute. This he has learned "by ear" of course, and he tries to practise it "by rote", with hazards that surpass any "calculated risks".

In medicine, as we know, folk-wisdom as a substitute for knowledge of the physical phenomena is now largely relegated to the history books; but folk-wisdom as a substitute for the psychosocial phenomena still flourishes widely and, of course, even with its hazards, serves far better than would "total blackouts" for this part of our lives.

Here is the burden of my first premise. It is the actual and haphazard use, and possible abuse, of the psychosocial factors in medical care that constitute a front-line challenge to the modern social sciences. To perceive that optimum medical care basically involves systematic knowledge and skill in both sets of phenomena provides sufficient foundation and justification for long-term co-operation. If we add to immediate therapy the responsibility for preventive and rehabilitative care, the challenge grows even stronger. As long as this basic premise holds, that potentially the physical and social sciences go hand in hand toward maximum medical care, I, for one, have incentive enough to stay committed to research and teaching in league with the health teams.

I should like to comment briefly here on the popular notion of "miracles" in modern medicine, both as they concern drugs and inter-personal relationships. We hear much of "miracle drugs" and something of miracle relationships. The latter can happen in a doctor's office, on a community health project, or in a hospital.

I have seen the "miracle" more frequently in a hospital. In the more dramatic cases, the patient all but "jumps the gun" and gets better ahead



Prof. Leo Simmons

cian as a flowering of the art, the amount of exact knowledge of the physical phenomena has been woefully small and the utilization of the folk-wisdom concerning human beings in social relationships has been maximized—often with remarkable results, as we all know. In the healing arts, it is a marvel that so much has been done with so little exact knowledge. In matters of health, to be sure, and perhaps for all times and places every particle of specific knowledge of the physical "stuff of life" is very precious and probably primary. But even in recent times with the flowering of the physical sciences and their application to medicine, along with a partial eclipse of medical concern for the "social stuff of life", it is still doubtful that any physician would be able to

of the prescribed medications that are good, or in spite of the poor ones. The remarkable results often appear correlated with exceptionally fine performance on the part of the staff and co-workers, and with the initiative arising on the administrative, clerical, nursing, or auxiliary levels, or even within an inter-patient relationship. Or, more remarkable still, the key performance may consist of a master stroke of team work up and down the hospital hierarchy and even, believe it or not, include the patient and/or a key relative or associate on the team.

In short, all the relationships seem to click together for good, and newly tapped resources emerge for healing and for health. When such an event occurs, and it can happen even in a hospital, the attending physician may shrug his shoulders, grant that the unexpected has happened, and attribute the occurrence to happenstance—implying that it is probably not repeatable, and thus challenges no scientific consideration. "Just one of those things, you know."

This point of view is in sharp contrast to the medical attitude toward the "miracle drug". The challenge to medicine of the "miracle" drug are the quotation signs around the word. To them, it is no miracle at all but both understandable and repeatable.

Now that, precisely, is the challenge of the "miracle" relationships to the social sciences. We have to assume that this, too, is no miracle at all, that it is understandable and repeatable. Perhaps this, our perspective on psychosocial phenomena, is the best thing we have to share with the medical personnel.

A basic postulate of the social sciences is that people's behaviour and all their relationships are subject to systematic study and plausible explanations, in the light of sufficient antecedent factors. For scientific purposes, we cannot assume either caprice or accident in man's reactions on the grounds that they are "human nature" and therefore a product of good will, sheer cussedness, or happenstance. Such a proposition can have no place in a social science approach.

To put the matter more concretely, when we observe social data in a hospital we look for the underlying regularities wherever we can spot them. We have to assume that it is possible to look behind, around, and into the context of specific events for sets of forces and circumstances that will account for the behaviour, whether it be a frustrated supervisor, a hurried and harried head nurse, an indifferent orderly, an unco-operative patient, or one of those "miracles".

Almost dead now among us is the folklorish conviction that the relationships and behaviour patterns of people cannot be studied and plotted systematically. And when it comes to unravelling, and perhaps repeating, a social "miracle" in therapy where the recovery has been remarkable, our second key theme becomes highly pertinent — namely, the possible role of psychosocial factors in the etiology and dynamics of the illness. Of course, the major mishaps in hospital therapy are equally challenging and instructive, and they are with repeatable. But perhaps it is a bit more gallant to concentrate first on the "miracles"—the wonders that are worked on the wards.

#### Basic Social Science Concepts

When we try to understand human behaviour in social situations, what constants can we formulate? We hold that there are two broad-grouped, fundamental, and indispensable ones. In the social sciences we generally call them structures of relationships and forms of behaviour. Perhaps better terms are organizational systems and cultural patterns.

In the concept of structure, we try to identify the common or perhaps universal variables in organized systems. A simple and short-cut analysis of these includes six variables:

1. Individual differences in capacity that are either innate or acquired.
2. Some specialization as an outgrowth of these differences.
3. Lines of dominance or potential "pecking orders", also as a consequence of the differences.
4. Forms of co-operative activities made possible and assumed to be on the basis of instinctive, coercive, or voluntary responses of individual members.
5. Stations or positions held by individual members as a consequence of the system.
6. Performance of behaviour corresponding more or less with the stations held. This last we have come to call "role-determined" behaviours or expectations of behaviour.

So much, in brief, for the concept of structure. When we say society, we think primarily of groups of people and their structured relationships.

To the extent that the behaviour of people is not inborn or instinctive, the concept of culture is the key constant or independent variable as related to a structured system, the membership positions, and role performances. This concept of culture is as important to the principle of socially determined patterns of behaviour as is the concept of instinct for the inborn patterns of response. Its scientific formulations and refinements are regarded as major

social science discoveries. All modern social science theory makes of it a kind of keystone to their formulations.

Man's uniqueness among living creatures can be summed up very well in the claim that he is, above all others, a culture-building, culture-bred, and a culture-bearing creature. It is his culture that stabilizes for him his relatively instinct-free and amazingly modifiable behaviour. To an as yet immeasurable degree, man's behaviour—his acts, thoughts, and feelings—are culture-patterned, in sickness as in health. Thus, for the underlying regularities in group-structured human behaviour, look first and foremost to the culture patterns that characterize inter-personal relationships in structured group settings. These have to be studied, however, in both their formal and their informal aspects, as we shall see later.

Culture can be defined simply as earned, shared, and transmitted patterns of behaviour, involving acting, thinking, and feeling. These cultural patterns of performance, or social patterns of expectation, for a member of a structured group may impinge upon and influence him under varying levels of social pressure from conventionalized customs, technically known as folkways and mores, up through laws, and by means of moral and ethical codes. Their enforcement may be external, or even policed by associates of varying status, such as subordinates, peers, or superordinates; by the believed-in supernatural agents; and even more stringently by self-imposed restraints and compulsions that have been conditioned by previous experiences.

In short, the social science point of view is that human behaviour in structured group relations and culture patterns does follow regular patterns that may be understood and manipulated to very substantial degrees. That is the conceptual basis of the medical challenge to us, as I see it. It is the instrumental formulation by means of which we would whittle away on the "miracle" and try to make plausible and repeatable what is regarded as unique and mysterious (charismatic, we sometimes say) in the psychosocial aspects of medical care. You can thus see that a primary challenge to social science in medicine is to explore its practice within the social context where it takes place.

#### The Concept of Institution

The concept of institution is more limited and manageable than are the above concepts of society and culture. It also combines or integrates the ideas

(Concluded on page 98)

## Regional Hospital Co-ordination

THE Regional Hospital Council which has been set up by a group of hospitals in the Swift Current area of Saskatchewan can best be described as a voluntary association of hospitals in the interest of good hospital care.

Approximately 900 or three-fifths of the 1,500 hospitals in Canada have fewer than 50 beds; and about 600 or two-fifths have fewer than 25 beds. It follows that these hospitals serve small urban centres of population and their surrounding rural areas. This familiar hospital pattern throws into relief one of the major problems facing hospital planners and administrators in Canada and the United States today. It is the problem of how to provide a hospital service for the people in little communities and rural areas which compares favourably with the service that is available in cities.

This difficulty has existed for a long time but has become more acute with the tremendous strides which modern medical science has made in the past 50 years. The laboratory became available to aid in diagnosis at the bedside and in post-mortem examinations. Progress was made in physics; and the extended use of x-rays and the electrocardiograph opened up a fresh approach to the disorders of the circulation. Physiotherapy recognizing the value of heat, light, massage and graduated exercises, has become available. New techniques have been brought into use in plastic surgery and in psychological medicine and neurology. All this is reflected in the large hospital by, for example, the extensive x-ray departments and elaborate pathology laboratories and physiotherapy departments. Neither the equipment nor the staff can be obtained for the small hospital for they are both expensive and, unless used to capacity, quite uneconomical. Even if money were no object to the hospitals and sufficient numbers of professional staff were available the duplication of expensive treatment departments in an area would surely be wasteful.

But the cost of services is an ever present concern of every hospital; while qualified personnel, such as path-

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ologists, radiologists, physiotherapists, dietitians and medico-social workers are in short supply. The question then resolves itself into how these small hospitals may share such services in order that they can achieve and maintain high standards of hospital care. The second problem, or it might be regarded as an associated problem, is the existing high cost of operating the small hospital. It does not provide many of the departments found in the large hospital. There is likely no x-ray treatment department, no cancer or psychiatric clinic. For this reason there is a natural and proper tendency for major surgical cases to be referred to the large hospital where better operating facilities and post-operative nursing care are available. The latter involves the large hospital in a comparatively higher ratio of staff to patients than is necessary in the small establishment. Despite all these factors, the cost per patient day is as great in most small hospitals as in many large ones.

It has long been suggested that the only practical answer to these two problems which have been posed is a co-ordinated regional hospital service. Such a concept of hospitals working together is not a new one except in Canada and the experience of other countries undoubtedly points the way.

### The Hospital System in Great Britain

In Great Britain prior to 1948 two main groups of hospitals were in existence — the voluntary and the municipal hospitals. The voluntary hospital tradition was strong in Great Britain and remains so in the Commonwealth and in the United States. On the continent of Europe, on the other hand, hospitals have been established principally through public funds for many years. It is sufficient to mention that the voluntary hospitals in Britain, with histories dating back to the 16th and 17th centuries, had been facing continual financial crises since the turn of the present century. On the other hand, the municipal hospital, develop-

ing out of the Poor Law Infirmarys, failed to keep pace with the advance of medical science except in a few areas, while the provision for the chronically ill was most inadequate. Even before World War II it was apparent that the time had come for the two systems to be welded into one, as had been envisaged in a report by Lord Dawson of Penn as far back as 1921.<sup>1</sup>

At the outbreak of World War II, 30,000 casualties a day were anticipated and a unified regional hospital service, enabling the transfer of cases quickly from one hospital to another, became essential. The Emergency Medical Service was formed. London and the Home Counties were divided into Regions, known as Sectors, with headquarters in the London Teaching Hospitals. Although the casualties were far fewer than expected, the system, when called upon in 1940, worked well. Then the National Health Service came into operation in Great Britain on July 5th, 1948. The ownership of all hospitals, save certain ones operated by religious orders, became vested in the Ministry of Health. The country was divided into 14 regions for hospital purposes, each region being associated with a teaching hospital and covering a population of from one to three million people.

In each region is a Regional Hospital Board, consisting of voluntary members, charged with the task of planning for adequate hospital facilities. The individual hospitals are grouped together, usually geographically, under a governing body known as a Hospital Management Committee. Both the Regional Hospital Boards and the Hospital Management Committees are corporate bodies set up under the National Health Service Act, 1946.

The arrangement of the hospitals in groups is interesting, for certain experimenting has taken place as to the size and the type of the groups. In some groups it is possible to find one or more acute general hospitals, a hospital for the chronically ill, a mental hospital, and a sanatorium. In certain other cases, mental hospitals and sanatoria have been arranged in separate special hospital groups. Though the optimum size of a general hospital group is regarded as 1,000 beds, in

<sup>1</sup>For references, see bibliography on page 82.

practice, groups range from about 400 to over 2,000 beds.

In order to carry out its planning functions, the Regional Hospital Board is responsible for allocating the capital monies it receives from the Minister of Health. Each group submits a list of its capital requirements and, as capital monies are scarce, a regional priority list is prepared. The Regional Hospital Board also employs consultant medical staff and arranges area services, such as thoracic surgical centres and plastic surgery units, where more than one hospital group is involved.

The Hospital Management Committee is responsible for the administration of its group of hospitals and operates through its Chief Administrative Officer who is often the Superintendent of the largest or parent hospital in the group. The Chief Administrative Officer will be supported by his accountant (finance officer) and purchasing agent (supplies officer) and various other administrative and clerical staff. The task of the Hospital Management Committee and its officers, in addition to operating the group, is to assess the needs of the area, to integrate the existing services and to use the available beds to the best possible advantage. In some cases the use of a hospital has been completely changed. For example, a little-used infectious diseases hospital might be converted for the treatment of tuberculosis, or it might be decided to use all the beds in a small general hospital for one specialty, such as ear, nose and throat. It is possible to arrange all admissions in the group through a central admissions bureau, thus greatly assisting general practitioners when, as is usually the case, beds are extremely scarce. Considerable integration has taken place in other phases of hospital administration. Salaries and wages are usually paid from the group central office, accounts are similarly dealt with, while nearly all hospital supplies are purchased under contract or tender negotiated centrally. The maintenance of buildings is looked after by a group engineer who, with a staff of tradesmen, *i.e.*, painters, plumbers, et cetera, carries out a considerable amount of work by direct labour.

The system has undoubtedly produced tremendous improvements, despite the lack of capital monies for new building. Voluntary interest and financial support lapsed sadly in the early years of the National Health Service; but all forms of voluntary activity have since been encouraged and in most areas flourish through Hospital Leagues of Friends.

One of the valid criticisms which can be levelled at this scheme is the dichotomy which has been continued

between the preventive services, which remain the responsibility of the local health authorities, and the treatment services. Effective liaison has not always been achieved; and the administrative problems arising from this arrangement too frequently act to the detriment of the patient.

The reason for referring to the hospital system in Great Britain is that the hospitals there are integrated to a greater degree than those in most other countries. The majority of the hospitals in France and the Scandinavian countries, numbers of which I have had the opportunity of visiting, are state hospitals and, rather than discuss their form of organization here, it is probably more profitable to consider the hospitals of the United States where the hospital system offers the greater contrast.

#### Hospitals in U.S.A.

For legal purposes, hospitals in the U.S.A. are classified into three groups:

Governmental: federal, state, county, municipal, and city.

Voluntary non-profit: church, fraternal, other types of non-profit associations and corporations, or industrial.

Proprietary: individual ownership, partner ownership, or corporations organized for profit.

Hospitals in the United States are naturally not as old as those in Europe; approximately only 7 are more than 150 years old, and only about 80 are more than 100 years old. Almshouses were probably the forerunners of the hospitals. One in Philadelphia was opened in 1713 while the Poor House of the City of New York, from which the Bellevue Hospital originated, was established in 1736. These, however, were establishments for the sick poor only and nothing then existed for the sick who could afford to pay. Not until the early 19th century were the first voluntary general hospitals built, such as the New York Hospital and the Massachusetts General Hospital. State Mental Hospitals began to be constructed about this time, while this period also marked the first hospitals for army and navy personnel. Few Church hospitals existed before the middle of the 19th century, though in the following 50 years, considerable numbers came into being.

At the beginning of this century most of the hospitals that existed were either voluntary or private hospitals. Government hospitals then were for nervous and mental diseases, while there were city hospitals for indigents.

As in all countries of the world, the 20th century saw a change in the status of the hospital in society. No longer was it just a place for the treatment of the indigent sick but

was now recognized as the best and safest place to be in the event of sickness.

Since the depression of the thirties, governmental hospitals have been greatly extended and the influence of government financial assistance has progressively increased. This financial assistance has come to hospitals through different channels which are worth noting.

The Public Works Agency, a federal body, was set up in 1933 and its workings soon had a definite effect upon the quantity of hospital construction being carried out. Up to 30 per cent of funds needed for hospital construction could be obtained through the Public Works Agency.

Through the Reconstruction Finance Corporation, private and governmental hospitals could obtain federal aid. Many loans were granted, though their conditions as to amount, duration and income, varied with the individual application.

In 1941 came an amendment to the Lanham Housing Act whereby grants could be made to both governmental and non-governmental hospitals for building purposes. Under this legislation the non-governmental hospitals received greater assistance than from any of the earlier programs.

Although, as has been shown, there has been an increasing amount of federal aid in the sphere of hospital building, the non-governmental hospitals have maintained their independent position by virtue of the fact that 75 per cent of their operating expenses is still obtained from patients' fees.

It has been seen that hospitals in Britain have become organized in a cohesive regional pattern. It is now proposed to examine the trend of the hospitals in the United States, which are independent and strongly determined to maintain their independence, towards this concept of regional organization.

#### Regional Plan in Maine

Probably the earliest arrangement of hospitals working together is in Maine, where a plan was started by the Bingham Associates Fund<sup>1</sup> in 1931 with 22 participating hospitals. The Tufts College Medical School provides for continuing professional education, while the New England Medical Centre and the Joseph H. Pratt Diagnostic Hospital serve as clinical base hospitals. Diagnostic facilities, in such services as pathology, x-ray and electrocardiography, are co-ordinated and made available to all the hospitals. There is a flow of professional personnel and services from the large hospital to the small, and yet a flow of patients, specimens and records from

the small hospital to the large. This is, in fact, the underlying feature of all schemes of hospital co-operation.

In 1942, the American Hospital Association set up a Commission on Hospital Care which was supported financially by the Commonwealth Fund, the W. K. Kellogg Foundation, and the National Foundation for Infantile Paralysis. It is interesting to note the following remarks in the introduction to the book *Hospital Care in the United States*: "We frequently refer to our splendid system of hospitals, whereas actually there is none. Government units, church bodies, philanthropists, industries, and individuals have participated in the construction of hospital facilities. The diversity of background and objectives of the sponsoring interests has resulted in widely disparate patterns of organization, administration and control of hospitals. There is very little co-ordination. In some instances, there even may be competition." This

was, of course, fair but strong criticism. Since that time there has been much thought given to the idea of hospital co-ordination and the regional planning concept.

#### U.S.A. Hospital Survey and Construction Act

The Hospital Survey and Construction Act came into force in 1946 and, as well as providing considerable funds for hospital construction of both governmental and non-governmental hospitals, it made available three million dollars for a survey of hospital needs throughout the United States. As this related to the studies already being done by the Commission on Hospital Care, a co-operative agreement was made by the Commission with the United States Public Health Service for the continuation of the work. The Hospital Survey and Construction Act stressed the concept of regional hospital planning. Among the recommenda-

tions of the Commission on Hospital Care are the following:

1. The interchange of service and equipment among hospitals should be carefully considered in planning for the systematic provision of hospital care in all areas.

2. Hospitals should arrange for the integration of services which would make available consultation services and the part-time services of radiologists and pathologists in small institutions which individually would not be able to finance effective programs of this type on a full-time basis.

3. Co-ordinating agencies should be established to assist with the development and maintenance of relationships among hospitals. The membership of these agencies should include representatives of the hospitals, of the medical and related professions and of all health organizations functioning in the area.

4. The medical profession should exert its efforts to develop the necessary medical staff co-operation required for the establishment of an effective integrated hospital system.

#### Rochester Plan and Others

Another successful scheme of regional hospital co-operation has been the Rochester Plan<sup>4</sup>. This was established in 1946 with the financial and advisory assistance of the Commonwealth Fund<sup>5</sup>. The scheme, which includes some 23 hospitals in upstate New York, allows for the planning of adequate facilities throughout the region, consultative services in clinical and laboratory medicine, the development of joint administrative services, such as group purchasing, and educational programs for professional and technical staffs.

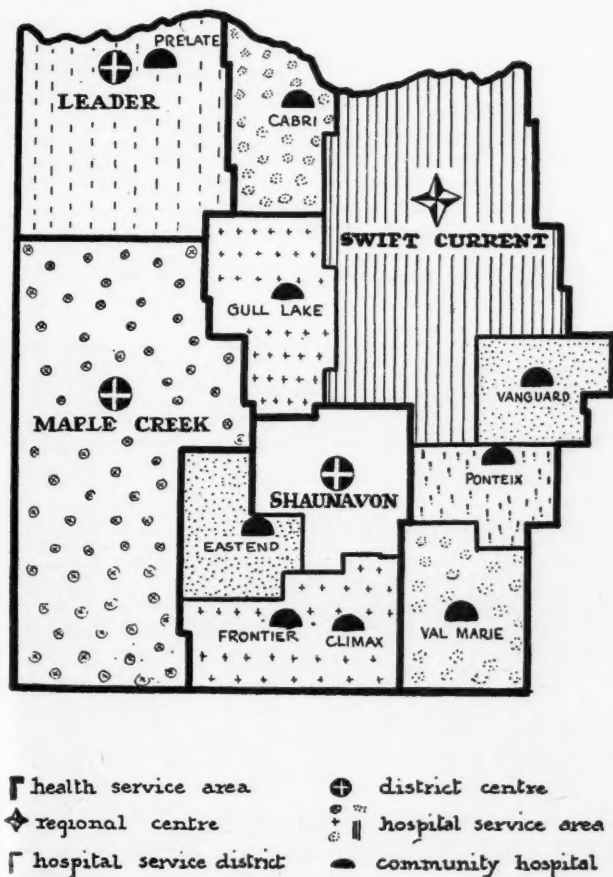
Yet another scheme is the Memorial Hospital Association of Kentucky, a subsidiary of the United Mine Workers of America Welfare and Retirement Fund. Ten hospitals are to be built in Kentucky, West Virginia and Virginia, whose services will eventually be as closely integrated as any group of hospitals in Britain.

In addition to these individual projects, many States have set up hospital councils such as the Michigan Hospital Council with representatives of all the health agencies in the area.

The purpose of referring to the hospital systems in Great Britain and the United States is to try and show that, despite their fundamental difference, i.e. nearly all hospitals in Britain are now state-owned, there is a degree of similarity in the development of the regional hospital concept.

What has taken place, and is still taking place, in these countries, cannot

Figure 1  
Hospitals Forming the  
Regional Hospital Council



be ignored by hospital administrators and planners in Canada.

### Saskatchewan

As Saskatchewan is the scene of the experiment, it is perhaps fitting to emphasize certain features of the province, even though they may be generally well-known. The province of Saskatchewan extends southward from the Northwest Territories for a distance of 766 miles to the international boundary bordering the states of Montana and North Dakota. The average width is 335 miles and the total area is some 251,700 square miles. Though Saskatchewan is almost as large as Texas, most of its 890,000 people live in the southern one-third of the province. The extremely rural nature of the province is seen when it is realized that eighty per cent of the people live in communities of less than 2,500 and that only four of the cities have a population of more than 10,000.

In Saskatchewan there is only one level of local government, namely the municipality. The municipality is responsible for such local services as water, street lighting, and fire protection. Other services such as highways, mineral resources and social welfare are provided by the provincial government. Apart from the regional health boards, large school units, and union hospital districts, no level of government exists, at present, comparable to the "department" in France or the county council in Britain. The municipal unit has been the basis for public health services and also for medical and hospital care. The "municipal doctor" plan is an example of municipal activity in a medical care program. This is a tax-supported scheme under which a municipality employs a general practitioner on salary, thus ensuring medical coverage to a rural area which most likely would not otherwise have been able to attract the services of a physician.

Another way in which municipalities have participated in health affairs is by the formation of Union Hospital Districts, as mentioned above. These are groups of municipalities, towns, villages and rural municipalities who have linked themselves together for the purposes of building and administering a Union Hospital. Over 100 of the 160 hospitals in Saskatchewan are municipal and union hospitals and they account for approximately 60 per cent of all the beds.

For public health purposes, Saskatchewan is divided into regions, though as yet only seven of the thirteen proposed regions are fully organized. Authority for setting up health regions is

contained in a Public Health Act, amended in 1928, and the Health Services Act of 1944. Wisely, when a Health Survey Report<sup>6</sup> was drawn up in 1950, the hospital areas and the public health regions were made co-extensive. The hospitals were classified at this time into four categories: base hospitals, regional hospitals, district hospitals and community hospitals, though no attempt was made to lay down rigidly the services which each type of hospital should provide.

The Saskatchewan Hospital Services Plan is widely known in Canada so it is not proposed to elaborate on the scheme here.

In the Swift Current Health Region, which was organized in 1945, there is also a successful pre-paid medical care scheme which has been in operation since 1946. This originally provided payment for hospitalization; but this part of the scheme was abandoned when the Saskatchewan Hospital Services Plan came into force in 1947.

### The Swift Current Project

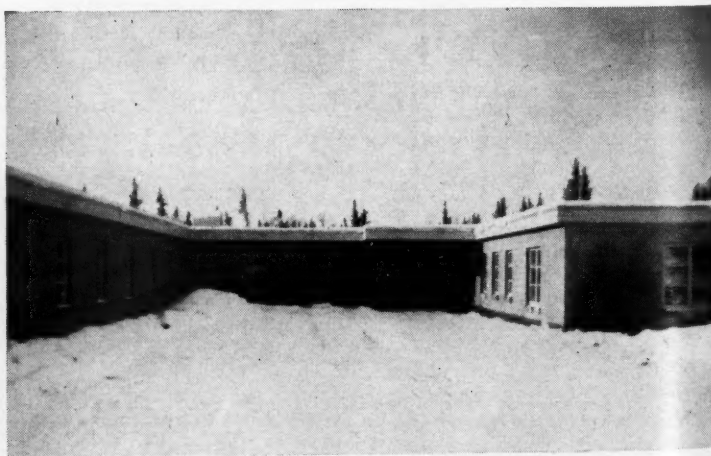
In 1954 the government of Saskatchewan submitted to Ottawa a proposal under which a regional hospital organizer would be engaged. Approval of this was received under the National Health program and the writer was appointed.

The Swift Current Health Region covers some 14,000 square miles and has a population of approximately 55,000. Two-thirds of the population is rural, living on farms or in hamlets of less than 100 people. There is the one city, namely, Swift Current, a few towns and many villages. Wheat growing and ranching are the main occupa-

tions, though the recently discovered oil wells are playing an increasingly important role.

It soon became evident that, although one or two of the leading personalities in the hospital field were enthusiastic, the majority of board members and hospital staff had given little or no thought to the subject. There are 13 hospitals in the region with a total bed capacity between 300 and 400 beds. After visiting each hospital to see what facilities existed, the prime task clearly was to talk on the subject of hospitals working together, to as many hospital boards and their staff as possible. Though interest was shown, hospital boards were, not unnaturally, mainly concerned with their own immediate problems. "How can our x-ray technician be given some further training?" "The doctor, who has just left, ran the hospital regardless of us as a board; what can we do for the future?" "How can we establish a proper admissions policy?" "We need a new extension. What facilities should it contain and what grants are available?" These are just a few of the questions which arose at various meetings. By endeavouring to assist the boards to find satisfactory answers to their problems, it was possible to establish good relationships and create the right atmosphere to discuss regional co-ordination. At the end of three months, a meeting was held with representatives of the 13 hospitals, members of the Saskatchewan Department of Public Health and the Regional Medical Health Officer. I presented two reports to the meeting — the first on the type of service which could be provided regionally and the second on

(Continued on page 80)



Emergency and ambulance entrance (reflecting the high proportion of Workmen's Compensation cases), morgue and autopsy room to the left of entrance in picture. Service wing with kitchen windows, extreme left, and to the right, the operating room and obstetrical suite wing.



*Main entrance and lobby wing with part of the medical wing to the extreme right. Exterior is white stucco on cement blocks. As with the maternity wing, expansion will take place with the extension of the wing on the right where a solarium is seen at present.*

## Uranium City

### Canada Looks North ↑

**Dickson T. Armitage,**  
B.Sc., Dip. H.A.,  
Administrator,  
Uranium City Union Hospital,  
Uranium City, Sask.

the provincial Department of Health for the services of their various consultants.

#### Long-term Planning

The new hospital was born of the prosperity of a boom town and in full confidence concerning the future of Uranium City. Long-term planning was very much in evidence. Future maintenance problems were simplified by the use of plastic-lacquer paints and durable shoulder-high wall covering in the corridors. Rapid methods of construction were employed where possible, using prepared and preformed materials, e.g., spray finishes on wall-

**D**URING the winter of 1953, the Minister of Public Health of the province of Saskatchewan approved in principle the operation of a hospital in the new community of Uranium City on Lake Athabaska. Through voluntary effort a hospital building was purchased for \$3,000. Recognizing the difficulties inherent in operating a hospital in a new area, the Department of Public Health agreed to staff and operate it, with the condition that it be equipped by the local community. It was hoped that this would provide temporary services so urgently required by Dr. D. W. McMillan until permanent facilities would be available.

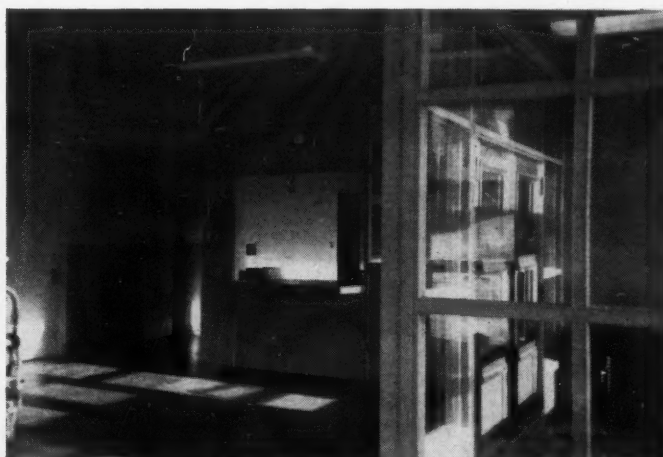
#### At \$30,000 Per Bed

A year ago, after only some five months of operation, the frame hospital burned to the ground. However, within two months the Department of Health had approved the site of a new 25-bed hospital and by winter a one-storey building, costing some \$30,000 per bed, had been conceived, drawn, and built. Those responsible for this remarkable feat were the architects, Webster and Gilbert, and the W. C. Wells Construction Co. Ltd., both of Saskatoon. The construction and equipping of the hospital was aided immeasurably by federal and provincial grants. The balance of the funds required was obtained through the sale of hospital debentures.

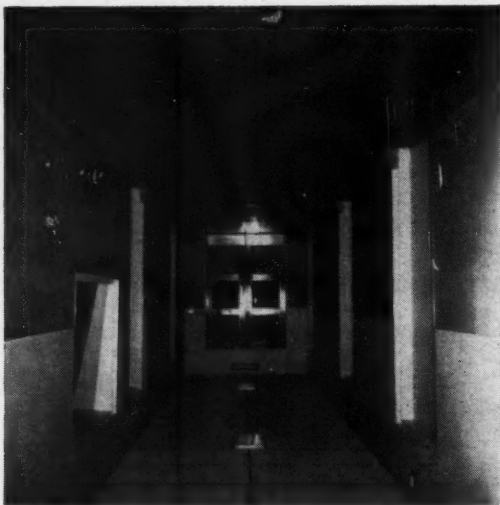
#### Design

Early on, the board had hoped that they could put up a building of a design already approved by the Department of Health. There came disillusionment when they were informed that the architect would have to plan one suited to the area and to the latest

specifications and design. However a medical and lay team set forth with perseverance, visiting many hospitals in Saskatchewan before deciding upon the final design. In the construction, equipment and organizational planning, the board relied upon the Hospital Administration and Standards Division of



*Main entrance, lobby and information desk. Two doors leading to the Public Health Clinic are at the extreme left. Unseen is a separate Clinic entrance.*



*Maternity wing corridor with nursery observation window at right. The ceiling is of acoustic board panels, removable for easy maintenance of overhead duct and pipe work.*



*Standard ward accommodation is the two-bed ward. Interior decorating is in speckled tones of plastic-lacquer paints.*

board interiors, acoustic tile on ceilings, linoleum tile floors on concrete floor slab, et cetera.

The accommodation includes 6 single or isolation rooms, 8 two-bed wards, one three-bed children's ward, 14 bassinets, and a separate staff residence. All the diagnostic facilities were planned for a 55-bed unit, as well as the general services including the dietary department equipment, heating, laundry, water supply, and sewage facilities. The emergency department is provided with examination and recovery rooms at one side, with autopsy room and morgue on the other side. The operating room and delivery areas are immediately adjacent to the central

supply room and occupy a terminal portion of a T-wing. The other terminal portion of the wing is occupied by a nursery, and an isolation room.

#### **Double Corridor**

The main nursing station of the hospital is located at the cross corridors in the centre of the building, in the medical-surgical wing, with a full view of the public entrance and corridors leading to the x-ray department, emergency entrance and nine-bed maternity wing. The provision of patient-nurse two-way speaker system and some use of the double corridor plan has reduced to a minimum the distance problems inherent in a spread-out one-storey floor

plan. Facilities for Public Health and Indian Affairs nurses are included in the main hospital.

#### **Pioneer Community**

The Uranium City area is a prosperous mining community of approximately 5,000 population. The town itself has some 2,000 persons and has grown rapidly from its inception three years ago as a planned community. It serves as the business and social centre for the entire Beaverlodge Development Area on the north shore of Lake Athabaska, in the northwestern corner of Saskatchewan. Milk is flown in daily at 60 cents a quart. A heated water truck makes the rounds of the homes selling this commodity at \$1.00 per barrel. The community is rapidly becoming settled, with municipal sewage and water being installed during the summer.

At present there are two physicians working in partnership in the area. They are under contract with the various mines, some of which are accessible only by air. Their practice is an extensive one in a youthful community, with hospital care coming under the Saskatchewan Hospital Services Plan.

#### **Supplies by Barge**

At certain times of the year the temperature drops to 60 below zero, cold but with low precipitation, thus calling for special construction and building precautions. It was originally hoped that the hospital could be built without having to resort to air-freight for construction supplies. Cement blocks were manufactured on location and fabrication was carried out wherever possible. The supplies were brought north, from Edmonton down the Mackenzie River watershed by barge to Lake Athabaska. Costs were high enough as it was but, with the closing of navigation September 15, the balance of supplies had to be taken in during the autumn via air-freight. To some extent this is reflected in the cost of the hospital at over three quarters of a million dollars for the 25 beds.

#### **Accomplishment**

The settlement has grown rapidly from nothing into a town. However it is still in strange contrast to the proud accomplishment — the hospital on the hill. The board had many trials and tribulations during its early days and in the words of P. W. Goldring, secretary: "It was very sad that the little hospital which took a lot of time and effort . . . was lost by fire; but the community has a new and modern hospital — so perhaps the effort was not made in vain."

We always like those who admire us; we do not always like those whom we admire. — *La Rochefoucauld*.

## Does Your Community Need

# A Long-Term Hospital?

**W**E KNOW that one of the chief causes for the present hospital bed shortage is the number of chronic patients who, although they do not need acute care, are compelled to remain in the general hospital because there is no long-term institution in the community. Thus cases that need urgent care cannot be admitted. This, of course, is a vicious circle as the long-term case is occupying a bed that costs as much to operate as if he were critically ill. A properly planned chronic hospital can be operated for approximately one third of the cost of operating a general hospital. Surely from this point of view alone it would be worthwhile to consider whether or not your community needs a long-term hospital because the cost of hospital care is the concern of us all.

However, let us not lose sight of

*\*From an address by Mrs. C. C. Warren, as president of the Women's Auxiliary to Gorge Road Chronic and Convalescent Hospital, Victoria, B.C., at the annual luncheon, Auxiliaries Division of the British Columbia Hospitals Association, in Vancouver, B.C., October, 1955.*

**Mrs. C. C. Warren\***  
Victoria, B.C.

another important aspect, the patient's outlook. Doctors, social workers, and other personnel agree that the chronically ill patient responds better to treatment in a chronic institution because of the program planned for his type of care. He is not surrounded by seriously ill people nor exposed to the routine this necessitates.

Do you really understand what a chronic hospital is? Quoting from the hospital act (Province of British Columbia): "A chronic hospital means an institution operated as a non-profit organization for the purpose of providing care and treatment for patients who are suffering from a chronic disease or convalescing from an illness".

The chronic hospital is not a nursing home and does not give simply domiciliary care but has a treatment program that includes physiotherapy. The actual nursing can be done by practical nurses who have studied body mechanics.

In our province we do have institutions at various places where the

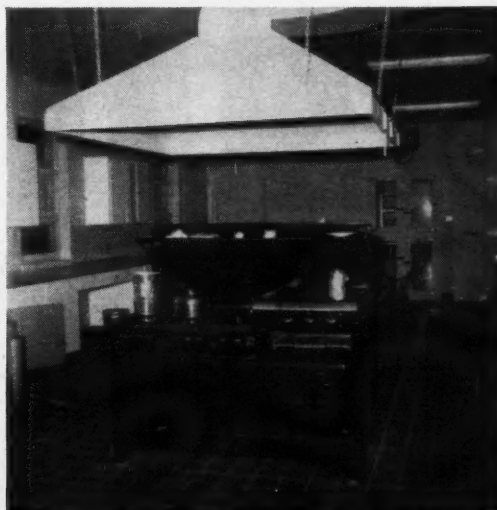
chronic patient can be sent if he is fortunate enough to be admitted. But in these cases, the patient must be sent away from home, friends, and relatives. Would it not be better if the patient were kept in his own community and treated by his own doctor? It is a challenge to provide adequate care within the community and a joy to see a patient eventually rehabilitated to his own home.

It is a well known fact that man's life span is increasing. Science is prolonging life with wonder drugs, standards of living are higher and, with the expanding frontiers of medical knowledge, disease no longer takes its toll of human life. This, however, poses its own problem: that of the care of the chronic sufferer. In the opinion of those advanced in the care of the chronically ill, this is becoming a top-ranking health problem of the continent. The figures are almost frightening. The last census, taken in 1951, showed Canada with one million people over 65 years of age. It is interesting to note that Vancouver had 10 per cent of her population listed

(Continued on page 88)



Main nursing station in centre of building at course of the medical-surgical wing, the maternity wing, the x-ray and emergency corridors and the corridor from the main entrance.



Kitchen area built to serve a 55-bed unit, propane-heated range, walk-in refrigerator and ventilation hood for future ovens and deep fat fryer.

# Cours, jolie courroie!

**L**A centralisation des services dans un hôpital moderne n'a plus besoin d'avocats pour plaider sa cause: elle a fait ses preuves. Il est maintenant hors de doute qu'il en résulte une économie de personnel, de matériel et, par-dessus tout — puisque le but poursuivi dans un hôpital ne varie pas et cela même dans le service le plus reculé — la plus grande satisfaction du malade. Il ne saurait toutefois être question de service éloigné lorsqu'il s'agit du département de nutrition dont le service des plateaux n'est en définitive qu'un secteur. Mais quelle n'est pas l'importance de ce secteur! Intermédiaire entre le malade et le département de production, il dispose de la redoutable faculté de faire valoir — ou de neutraliser — le travail de ce dernier. D'où l'on peut conclure immédiatement qu'on ne saurait mésestimer ou négliger un tant soit peu le fonctionnement de ce service, lequel contribue dans une large mesure à la bonne — ou mauvaise — réputation de l'hôpital.

Ces données ont été prises en considération par les autorités de l'Hôpital Maisonneuve. Situation du local, équipement, organisation et fonctionnement du service ont fait l'objet de longues séances d'étude, de consultations, de recherches, de visites expérimentales, et cetera. C'est la résultante de ces études et l'expérience de quinze mois de fonctionnement que le présent article livre aux lecteurs.

Avant d'attaquer le problème à sa racine et d'en poursuivre le développement, il faut noter qu'à Maisonneuve le service est également centralisé au point de vue service des diètes régulières et diètes spéciales. Tout passe sur la courroie. Le projet a d'abord semblé téméraire, mais la réalité prouve qu'il est possible moyennant la coopération du département de production, du personnel hospitalier dans les départements de malades, voire même du personnel de l'imprimerie. Nous ne saurions trop souligner l'importance de ces coopérations vraiment indispensables dans le bon fonctionnement du service. Ces diverses coopérations contribuent — et de si près! — à un service exact, rapide, de nature à faire honneur au personnel de l'Hôpital et à rencontrer les justes exigences du

**Sr Rachel Tourigny,**  
Administratrice,  
Hôpital Maisonneuve,  
Montréal, P.Q.

patient . . . lui qui est la raison d'être de l'Institution.

## Situation du local

Une brève description du plan général de l'Hôpital Maisonneuve nous permettra de situer le service des plateaux en regard de l'ensemble. Ce plan s'avère d'ailleurs très simple: tour centrale comprenant quatre ascenseurs — deux de chaque côté — vers laquelle convergent cinq ailes; deux à chaque extrémité s'ouvrant en forme de V. Entre les ailes B et C, situées à l'arrière, se dresse une cinquième aile à laquelle nous référerons comme à l'aile No. 3; elle ne compte que cinq étages, tandis que les quatre autres en comptent douze. C'est dans cette aile, au rez-de-chaussée, que se situe le département de nutrition: cuisine centrale avec ses différents secteurs dont la cuisine des diètes et le service des plateaux occupant le point de jonction entre la cuisine centrale et les ascenseurs. De chaque côté, séparés par deux corridors aux dimensions identiques, s'alignent les deux cafétérias, dont celui de droite, si vous observez les lieux de la cuisine même, voisine avec le buffet pour les visiteurs. Comme on peut en juger, le département de nutrition fait bloc à l'Hôpital Maisonneuve et beaucoup d'avantages en découlent pour le service des plateaux: proximité du département de production auquel il a accès par deux



*Sr Rachel Tourigny*

larges portes, proximité des ascenseurs par deux autres portes ouvrant sur le corridor central. Un de ces ascenseurs est exclusivement réservé au service des plateaux à l'heure des repas. D'autres avantages sont également à noter; proximité du bureau d'achat, de la réception des marchandises — départements occupant le sous-sol de la même aile — éloignement relatif des départements de malades, d'où réduction du bruit et conséquemment paix et tranquillité pour ces derniers.

## Description du local

L'inventaire et la disposition de l'équipement et des moyens de communication donneront lieu de constater que toutes les mesures ont été prises pour faciliter et accélérer le travail accompli dans ce secteur.

De la cuisine centrale, passons au local du service des plateaux par l'une des deux portes de communication; nous nous trouvons ainsi à l'endroit où débute le service quand a sonné l'heure de la préparation immédiate. A gauche, longeant le mur, une armoire en deux sections: section supérieure en bois avec portes à coulisses pour l'entreposage de la vaisselle et de la verrerie; section inférieure: armoire réfrigérée en acier inoxydable pour l'entreposage des portions et des breuvages froids; le dessus de cette armoire constitue une surface d'entreposage appréciée à l'heure du service.

A quelques pieds de cette armoire, dans le même sens de la longueur se trouve le convoyeur pour les plateaux. Ce convoyeur est constitué d'un comptoir dont la section de droite est chauffée et, moyennant les cavités rectangulaires qui y sont pratiquées ainsi que les étagères fermées de portes à coulisses qui s'échelonnent au-dessous, sert d'entreposage pour les aliments chauds. La section de gauche ainsi que l'extrémité sont réparties en étagères d'entreposage, sans constituer une armoire puisqu'il n'y a pas de portes. Au centre la courroie, cette jolie courroie blanche laquelle, à l'heure du service, transporte inlassablement les plateaux qu'on y glisse; au-dessus de la courroie, étagère d'entreposage; d'acier inoxydable, munie de fluorescentes.

A courte distance du convoyeur, dans le même sens également, le réchaud d'acier pour la vaisselle: bols à soupe, théières, tasses, soucoupes. Les plats de résistance sont empilés dans les "lowerators", étagères métalliques chauffées, automatiques et mobiles; pour l'instant les "lowerators" occupent l'angle à droite. A l'extrémité du réchaud pour la vaisselle, sur une table de même métal se dressent les trois urnes: deux pour le café, une pour l'eau chaude; cet alignement se ter-



"Elle courra, la jolie courroie"

mine par le bureau de l'officière en charge.

A gauche encore et longeant le mur, s'échelonnent l'armoire à pain sur le comptoir de laquelle est installé le grille-pain; et le monte-charge servant de transport pour les spéciaux ou repas servis en dehors des heures régulières. On a atteint l'angle où est installée une armoire d'acier en deux sections: section supérieure destinée aux réserves sèches: céréales, biscuits, sacs de thé, postum, sel, poivre, et cetera; section inférieure: lavabo destiné à l'entretien des salières et poivrières et comptoir de préparation des jus de fruit. Tout près se trouve un système permettant la communication verbale et instantanée avec les différents départements de l'hôpital et vice-versa; puis ce sont les deux portes ouvrant sur le corridor des ascenseurs, portes séparées par une armoire-séchoir; l'autre angle est entièrement affectée à l'entreposage des chariots pour le transport des plateaux servis; ces chariots d'acier inoxydable sont réparties en cinq étagères et munis de portes fermant hermétiquement. Le dernier secteur du service, celui qui occupe l'angle de droite, en sortant de la cuisine, est aménagé pour le lavage des plateaux moyennant un comptoir muni d'un lavabo; à proximité se trouve une table d'acier placée transversalement où les plateaux sont d'abord débarrassés; on élimine les restes, on opère un premier recurage et classifie la vaisselle; cette table n'est pas séparée de

sa voisine posée dans l'autre sens cependant, où s'alignent les paniers dans lesquels on place la vaisselle récupérée; les différentes opérations s'effectuent successivement sans qu'aucun transport ne s'impose, on n'a qu'à pousser légèrement les paniers vers la laveuse de vaisselle, laquelle accomplit bonne besogne, comme on le sait. L'installation de distributeurs électroniques de produits chimiques élimine l'essuyage même des verres, de sorte que, aussitôt lavée, la vaisselle peut être empilée sur l'un ou l'autre des deux chariots à étagères, servant de moyen de transport pour l'instant; il sera facile de s'en servir comme étagères d'entreposage au moment du service proprement dit.

La description du local sera complète lorsqu'on aura signalé les trois tableaux appendus au mur pour indications spéciales, le système de ventilation et ce dôme de vitres tout juste au-dessus de la courroie, destiné à assurer l'éclairage suffisant.

Cet inventaire suffit à prouver que le local est pourvu de l'équipement le plus moderne; reste maintenant à en faire un usage adéquat. C'est ce qui se produit à l'heure du service, question à laquelle nous passons immédiatement en décrivant les différentes phases du fonctionnement.

#### Fonctionnement du service

Le fonctionnement du service se divise en six phases: préparation éloignée, préparation prochaine, service

proprement dit, retour des plateaux, service des spéciaux et celui des goûters du soir.

#### Préparation éloignée:

Dans la préparation éloignée entrent sans contredit: la rédaction des diètes spéciales: calculée, diabétique, sans résidu, molle, liquide, légère, et cetera, lesquelles diètes, après avoir été établies, ont été imprimées et restent affichées en permanence afin de parer aux interprétations variées. La définition claire et précise de la fonction de chaque auxiliaire a également été rédigée de façon à faire saisir la part de chacune dans le travail d'ensemble et à servir de guide ou d'aide-mémoire au besoin.

Puis c'est la composition du menu-clef par le Chef-cuisinier en collaboration avec la diététiste de façon à ce que la variété d'aliments permette le service de certaines diètes sinon au complet, du moins en partie. La composition des diètes spéciales incombe à la diététiste. La polycopie de ces divers menus est effectuée par l'imprimerie, selon une disposition invariable; on a adopté un caractère facilement lisible et du papier de différentes couleurs selon la sorte de diète.

Le menu—sauf celui des diètes: molle, sans résidu, pour diabétique et cas d'ulcère—est distribué à tous les patients indifféremment, même aux cas de salles, par le personnel hospitalier en tenant compte de la diète évidemment. Ce menu porte le nom et le numéro de chambre de chaque mala-

de qui pointe d'un crochet les aliments désirés. Quant aux diètes non distribuées, elles sont remplies par la diététiste après une première entrevue avec le patient.

La collection des menus est effectuée par deux employées du service des plateaux qui procèdent ensuite à la confrontation de ces menus avec les fiches de contrôle. La diététiste opère le même contrôle de son côté.

Vient ensuite la totalisation des quantités requises, totalisation nécessaire pour le département de production. Une autre employée rédigera la liste des "spéciaux" ajoutés au menu.

Le menu du jour est affiché au tableau dès la veille au soir afin de guider les auxiliaires au cours de la seconde phase, c'est à dire la préparation prochaine.

#### *Préparation prochaine*

Cette seconde phase du service comprend sept opérations successives ou simultanées dont la plus importante est la préparation des aliments, laquelle relève entièrement de la cuisine centrale. Au personnel de la cuisine des diètes, incombe l'agencement et la répartition des portions selon les diverses diètes.

Tandis que s'effectue cette préparation des aliments, les auxiliaires préposées à la collection des menus procèdent à un second contrôle, relativement aux fiches afin de remplir les prescriptions nouvelles, d'ajouter ou soustraire les menus selon les arrivées ou les départs — détails fournis par les divers départements. Les menus des diètes spéciales sont ensuite intercalés aux menus réguliers selon l'ordre numérique et département, puis déposés sur le convoyeur, à l'extrémité appelée début du service.

D'autres employées ont préparé les items froids: beurre, lait, crème, jus de fruit, et cetera.

Quelques minutes sont ensuite employées à l'étude collective du menu régulier; l'officière en souligne les points importants et met en garde contre les erreurs toujours possibles.

Puis c'est le transport de la vaisselle sur les étagères d'entreposage à gauche de la courroie; les "lowerators" sont placés à droite près de la section affectée aux mets chauds, le chariot spécial à plateaux est roulé au début du service. Les items froids sont alors retirés de l'armoire réfrigérée et avec le pain, les biscuits, les sacs de thé, et cetera, sont placés sur les étagères ou le comptoir selon l'ordre pré-établi afin de faciliter le réperage. Les aliments chauds sont également transportés de la cuisine centrale ou de la cuisine des diètes et déposés dans les cavités du comptoir chauffé ou dans le ré-

chaud au-dessous, selon le cas.

#### *Service proprement dit*

Tout est prêt pour le service, ainsi qu'en attestent le groupement du personnel et des choses autour du convoyeur et l'arôme délicieux qui se dégage des mets et pique agréablement l'appétit. L'heure du service proprement dit est venue: le silence s'établit dans cette ruche bourdonnante. Chaque auxiliaire, de même que le personnel de la cuisine des diètes, prend son poste.

Les chariots destinés au transport des plateaux aux étages ont été mobilisés et alignés à l'autre extrémité de la courroie; l'employée chargée de regarnir le comptoir s'appête à sa fonction, tandis que la diététiste s'achemine vers son poste de contrôle, l'endroit où les plateaux quittent la courroie pour être placés sur les étagères du chariot. Les deux aides chargées de la disposition des aliments chauds sont gantées, en prévision de la manipulation des assiettes chaudes.

Il reste à mettre la courroie en mouvement; elle courra, la jolie courroie, non pas à fond de train, mais sans heurts, sans secousses, inlassablement, à moins qu'on ne l'arrête pour réparer une erreur ou combler un oubli. Ces arrêts représentent autant de lacunes et s'ils se multiplient au cours du service, ils le ralentissent considérablement et tout en prolongeant la période de travail, ils risquent de compromettre la satisfaction du patient. Voilà pourquoi toutes les mesures préventives ont été prises en fait de quantités d'aliments et d'entreposage de vaisselle; il incombe maintenant aux auxiliaires de tenir l'oeil ouvert et de déposer, au bon endroit, "élégamment", l'item dont elle est chargée *s'il est pointé sur le menu*. Les différentes couleurs des diètes constituent autant de signaux destinés à éveiller l'attention de celles qui sont préposées au service des diètes spéciales; notons en passant que des portions d'aliments ont été préparées de façon à pouvoir servir les diètes calculées.

L'officière a mis la courroie en mouvement; l'auxiliaire placée au début du service y glisse un plateau qu'elle a préalablement muni de: salière, poivrière, paquet de sucre, serviette de table et menu, items entreposés sur les étagères de l'extrémité. Le menu est placé de façon à ce que les aides puissent le lire facilement, et l'aperçoivent à distance. Le plateau avance lentement, mais inexorablement; de gauche et de droite, lui arrivent successivement les ustensiles, le plat de résistance sur lequel on pose un couvercle, la tasse et la soucoupe, le sac de thé ou autre breuvage selon l'indication, l'eau chaude, le bol à soupe

aussitôt fermé d'un couvercle; le carré de beurre, l'assiette à pain, le dessert, le jus de fruit, le lait, et cetera; le plateau a atteint l'autre extrémité; la surveillante consulte le menu, contrôle les items froids, soulève le couvercle du plat de résistance et si elle ne perçoit aucune erreur, passe le plateau à l'employé qui le dépose sur les étagères du chariot, en sauvegardant toujours l'ordre numérique afin d'en faciliter la distribution. Chaque chariot contient quinze plateaux, lorsque tous y ont trouvé place et que le dernier couvercle en est refermé, l'employé le munit de la marque d'identification: indicateur de bois portant le numéro de l'étage et la lettre du département, puis le conduit à l'ascenseur. L'opérateur de ce dernier en loge deux à la fois dans l'ascenseur et va les conduire immédiatement à destination, c'est à dire à l'orée de chaque département. L'hospitalière en signale l'arrivée en carillonnant le ralliement de son personnel sur le gong appendu au mur tout près du poste d'infirmières. *Les plateaux sont distribués immédiatement, selon la consigne émise et maintenue à tout prix.* Le manque de coopération relativement à ce point capital suffit à neutraliser le travail des départements de production et de service, de même qu'il provoque le mécontentement du malade.

#### *Retour des plateaux*

La collection des plateaux est effectuée par le personnel des départements. Salieres et poivrières sont enlevées des plateaux et posées sur le dessus du chariot, ce dernier est dirigé près de l'ascenseur et transporté au service ou l'opérateur le conduit jusqu'au premier comptoir à droite; là, on enlève salières et poivrières, pour fins de nettoyage et de remplissage; le chariot est ensuite poussé vers le comptoir à débarras où le plateau est libéré de son contenu; tout en éliminant les restes, on procède à un récurage sommaire; au besoin on laissera séjourner les assiettes dans l'évier rempli d'eau froide afin d'éliminer les matières adhérentes, on empile la vaisselle, on fait de même pour les plateaux lesquels sont transportés au comptoir spécial pour être lavés et remis en place. La vaisselle est ensuite placée dans des paniers lesquels sont dirigés vers la laveuse; deux auxiliaires reçoivent les paniers, classifient la vaisselle sur les étagères mobiles et vont ensuite l'entreposer à l'endroit convenu. Tandis que se poursuivent ces différentes opérations, l'employé chargé des chariots vaque à leur nettoyage et les entrepose. Il procédera ensuite au lavage du parquet. Le local reprendra son aspect coquettement

(Suite à la page 78)

## Metropolitan, Windsor

host for

## Disaster Institute



Left to right: E. R. Bevis, Ontario Civil Defence Co-ordinator; Dr. W. R. Waddell, Chairman, Board of Directors, Metropolitan Hospital, Windsor; Dr. K. C. Charron, Principal Medical Officer, Civil Defence Health Services, Ottawa; and Robert Buckner, Administrator, Metropolitan Hospital.

THE Metropolitan Hospital, Windsor, Ontario, was host for a disaster institute on April 5 and 6, 1956. Dr. K. C. Charron, principal medical officer, Civil Defence Health Services, Department of National Health and Welfare, was chairman of the meeting. Honourable Paul Martin, Minister of National Health and Welfare, addressed the delegates on the over-all importance of hospital disaster planning and civil defence. Greetings were brought to the institute by Mr. Bevis, representing the Honourable W. M. Nickle, Minister of Planning and Development, the minister responsible for civil defence in Ontario. Greetings from the city of Windsor were given by His Worship Mayor Michael Patrick, and from the board of governors of the Metropolitan General Hospital by the immediate past chairman, Lt. Col. W. L. McGregor. Dr. R. G. Struthers, secretary, Civil Defence Health Services Advisory Committee, Department

of Health, Toronto, acted as advisor; and Dr. Charron, as heretofore, was ably assisted by Dr. G. E. Fryer, medical consultant, Miss E. A. Pepper, nursing consultant, and J. E. Matthews, medical supplies officer, all of Civil Defence Health Services.

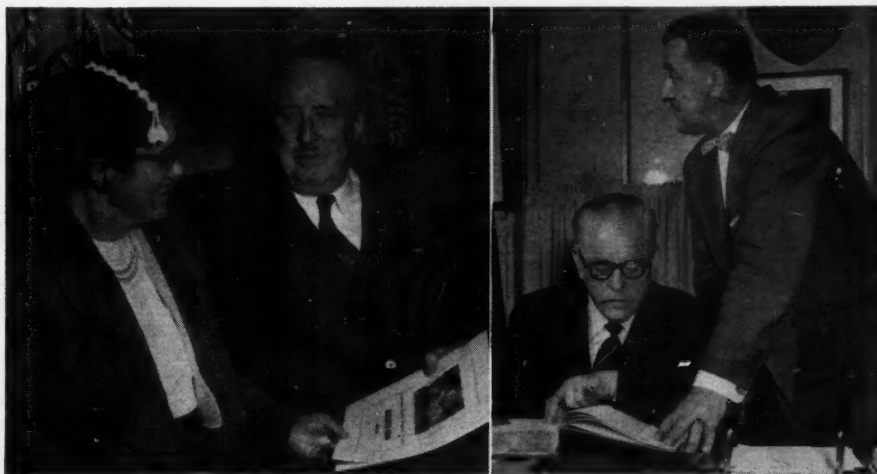
Robert Buckner, administrator of the Metropolitan Hospital, presented his disaster plan from the administrative aspects, followed by Dr. John MacLennan of the medical staff and Miss Ruby Thompson, director of nursing services. The Leamington District Memorial Hospital's plan for small hospitals was presented by Miss J. M. Tillett, administrator, and Dr. H. R. Nicklin, chief of staff.

The institute was attended by delegates from some 27 hospitals, the majority of whom were from western Ontario but all parts of the province were represented. Each hospital had the administrator, director of nursing, and the chief of the medical staff or his rep-

resentative present. The first day was devoted mainly to the presentation of the disaster plans of the two hospitals; and, on the morning of the second day, the delegates assembled for discussion in three groups — administrative, medical staff, and nursing. During the afternoon of the second day each section presented its report and this produced some lively discussion. The integration of a hospital's disaster plan into the over-all civil defence planning was discussed also at considerable length.

Communications were considered to be of vital importance in the development of an adequate disaster plan for any hospital. Such planning should include, therefore, liaison with the press and radio. It was considered desirable, during the planning, that members of these organizations be invited to attend a meeting of the hospital disaster committee to learn of the hospital's

(Concluded on page 108)



At the right, Mrs. J. M. Tillett, administrator of Leamington District Memorial Hospital, Leamington, Ont., discusses the program with Dr. H. R. Nicklin, Chief of Staff at the same hospital. Left, in studious pose are seen a visitor, Arthur Dahl, Chief Civil Defence Administrator for Denmark, and Michael T. Patrick, Mayor of Windsor. Pictures: Windsor Daily Star.

# Through 50 years } A Helping Hand to Children

THE OBSERVANCE by the Montreal Children's Hospital of its fiftieth anniversary was an outstanding public relations program which captured the interest of all Montreal. Highlights of the program were: the largest birthday cake ever seen in the city; publication of a historical booklet; a public forum on child health which nearly 1,200 parents braved the winter's snow to attend; and editorial kudos in Montreal's daily newspapers. This hospital's anniversary observance—which had its climax in a cornerstone-laying ceremony last month—exemplifies what any hospital can do to develop understanding of its activities and win public good-will through public relations.

Planned around the theme "Through 50 Years: A Helping Hand to Chil-

Donald J. Duff\*,  
Montreal, P.Q.

dren", the birthday program was launched at the hospital's annual meeting in September. Rather than a short period of intensive activity, the Anniversary Committee decided upon a limited number of events and projects—but all of them well-planned and executed.

Historically, The Montreal Children's Hospital had its origin as a vague idea in the mind of one man, the late Dr. Alexander MacKenzie Forbes, onetime professor of orthopaedic surgery at McGill University. Dr. Forbes, strongly aware of the plight of crippled children, enlisted the aid of Montreal business leaders to further his hopes

for "a small cottage hospital to comfortably house from twelve to fifteen children." The first building was a rented house, with bed space for ten youngsters. In 1905 the Legislative Assembly of Quebec passed an act incorporating "The Children's Memorial Hospital."

Through the years the hospital expanded its facilities and services, always willing but never quite able to take care of all the children in need of hospital care. The brightest chapter in the hospital's history was written in May, when the Hon. Paul Sauve, Quebec's Minister of Social Welfare and Youth, laid the cornerstone of the hospital's new 385-bed buildings—a tribute to the generosity of Montrealers, whose gifts are making the new facilities possible.

It was to capture some of the drama of the hospital's evolution that the anniversary program was planned. The hospital's name had been changed from "Children's Memorial" to "Montreal Children's", earlier in 1955, and one of the major objectives was to publicize the name change and the reason for it—the development, through a half century, of a small orthopaedic hospital into a complete health and medical centre for children.

To develop planning and direct activities, the anniversary committee was formed, comprising the hospital's executive director, a board member, press and radio representatives, and public relations counsel. The planning period began several weeks in advance of the annual meeting, which launched the program.

It was agreed that a major project should be publication of a lively and not-too-long history of the hospital. Several attempts had been made in the past to write such a booklet; but amateur writers had always found the scrapbooks and minutes of several hundred meetings too much of a challenge. This time the hospital retained the services of a professional writer and gave him full access to all pertinent



Cake donated to the Montreal Children's Hospital for its 50th anniversary party as a tribute to the hospital's record of humanitarian service.

\* The author is a public relations consultant with wide experience in the hospital field. He is associated with the firm of Brakeley Public Relations Ltd.



*New 385-bed Montreal Children's Hospital. The right wing was the former Western Division of the Montreal General Hospital. The architects are McDougall, Smith, and Fleming, Montreal.*

files. The result, after six weeks of intensive research and writing, was "The Children's Story". In the foreword, by the hospital's president, it is pointed out that "this booklet is not intended as a definitive history of the hospital . . . but to show how this remarkable institution has grown in stature and service, fulfilling the ambitions of its founders."

The booklet measures 5½ by 8 inches and has only 16 pages within its covers. It had been planned to print 5,000 copies but public interest and demand resulted in a press run of 12,000 copies. Requests for the booklet have come from many parts of the world, mostly from former interns, residents and students nurses at the hospital. Copies were mailed to community leaders and contributors to the hospital's financial campaigns.

Following the annual meeting, the anniversary committee decided to promote a public forum on child health. Choice of a location for the forum evoked considerable discussion and an auditorium well away from Montreal's downtown area was decided upon, primarily because of its parking facilities. It was agreed the forum should feature "local talent" rather than imported experts. The panel was headed by Dr. Alan S. Ross, professor of paediatrics at McGill University and physician-in-chief of the Montreal Children's Hospital, who enlisted the support of a

child psychiatrist and a prominent woman paediatrician, both of them on the hospital's medical staff. The forum was chaired by a non-medical professor noted for his wit.

Press and radio co-operated in promoting the forum, which was free, in advance. The Quebec Federation of Home and School Associations sent notices to all its members and announcements were sent to school boards, service clubs and other organizations. Parents were the primary audience, so the forum was titled "You and Your Child's Health." Questions were invited, for consideration by the panel, and nearly 300 were received—ranging from queries about flat feet and threadworm to jealousy and heart surgery.

The anniversary committee had some misgivings when the day of the forum brought Montreal's first winter snow. But the evening's driving conditions apparently were no deterrent. The auditorium was full, a radio station broadcast the forum highlights, and the press gave full coverage to the event. The forum's success has prompted the hospital to consider inaugurating the health forum as a regular activity. Consensus of editorial comment praised the hospital for its awareness of community interests and the forum as a constructive and forward step in preventive medicine.

Concurrent with the special events and projects, the hospital issued many feature stories to daily and weekly newspapers. Radio stations featured interviews with hospital personnel, particularly those associated with the hospital for most of its fifty years. Television interviews also were arranged and a television "tour" of the hospital's present outmoded facilities was widely discussed. "I certainly see why you need new buildings," wrote one viewer. "The best of luck in your new home!" exclaimed another.

Final project, apart from the cornerstone ceremony was a birthday party, just before Christmas, for patients and staff. When plans were announced, Montreal's bakers offered to bake the largest cake in the city's history. Their contribution was the subject of front-page photographs in a number of Canadian newspapers.

What have been the benefits of the fiftieth anniversary observance? Certainly the most important benefit has been a greatly increased awareness, understanding and appreciation of The Montreal Children's Hospital on the part of the public — especially parents, who look to the hospital for help, and hope. For the hospital, the anniversary program has opened new vistas of communication with its various audiences, or publics.

*Montreal knows* The Montreal Children's Hospital

**A** CHEERFUL nurse, hot meals and a comfortable bed; in the background a doctor who orders medicine, undertakes operations, and generally supervises the activities of the patient—this is the popular concept of hospital care.

A different view is expressed in a recent letter which we received. This writer asks us to see that her friend "is given the very utmost attention, see that her husband supports his wife in a better fashion than he has up to date and that she gets more spending money."

Between these two positions lies the responsibility of the hospital as a corporation and it seemed wise that we attempt to define the relative responsibilities of the trustees, the medical staff and the hospital employees in meeting the needs of the individual patient.

The supporters of the hospital are bound together under the terms of incorporation; and in the constitution they accept the responsibility for providing good hospital care for those who need it. The subscribers and other interested supporters authorize a board of managers, trustees or directors to act on their behalf. The board must then provide suitable physical facilities, engage competent employees, and appoint a medical staff who will be responsible to the board for the quality of medical care provided in that hospital.

Provincial legislation spells out the responsibility of the board in the appointment of doctors who may practise in the hospital. In British Columbia the regulations under the Hospital Act require that "No person may attend or treat patients . . . unless he is a member in good standing of the College of Physicians and Surgeons of B.C. . . . and unless he holds a permit from the Board of Management to practise medicine in the hospital."

Now here we have a group of men who are not doctors charged under the Hospital Act with the responsibility for issuing permits to individual doctors to practise medicine in the hospital and for denying such permits at their discretion.

To assist the board in assuming this responsibility it is essential that the doctors who are using the hospital constitute themselves into an organized medical staff. In fact the regulations of the Health Act require that "the Board of Management of every hospital organize a medical staff of which every physician practising within the hospital shall be a member."

The board then appoints a medical

**For Trustees Only:**

## The Quality of Medical Care

staff in accordance with the best advice which can be obtained. It looks to that medical staff for guidance on further appointments, for definition of the medical and surgical privileges of each staff member, and for a general supervision of the quality of medical care and the completeness of medical records.

The type of medical staff organization will vary with the individual hospital. The large teaching hospitals and those operated by the federal and provincial governments have the "closed" hospital organization. The patient, having qualified for admission, is received into the appropriate ward and is treated by the chief of that service, with his associates, residents and interns. This type of organization provides excellent opportunities for medical teaching. It also permits standardization of treatment methods and a careful analysis of the results obtained.

Other hospitals have the "open hospital" type of staff organization. Here the private doctor sees the patient at home or in his office and refers him to the hospital. The patient is admitted to a suitable ward and the referring doctor follows the patient to the hospital and orders his treatment, calling such consultants as he may require.

In the "open" hospital, medical staff organization is particularly important, for it is through such organization that the board and the supporters of the hospital are assured of a high quality of medical care. In the very small hospital the medical staff may act as a single unit in supervising the professional work. Where there are sufficient doctors on the staff, it is usual to divide

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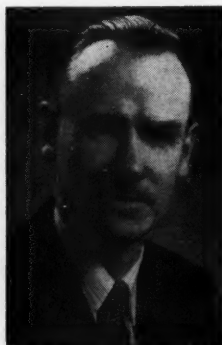
the group into the clinical services and into various divisions of the staff — active, courtesy, et cetera.

The "active medical staff" is the backbone of the organization and through its committees it will ensure good medical care. The Records Committee reviews the clinical reports on each patient. The Credentials Committee reports on the qualifications of new applicants for staff appointment; and defines the scope of the privileges which shall be granted to each doctor practising in the hospital, based on his individual training and experience. The Tissue Committee reviews the results of surgery and assures the staff and the board that operations undertaken in the hospital have been justified by the pathological findings in the tissue removed.

In the small hospital individual members of the medical staff may act in rotation to carry out the functions of these committees, or the staff may act as a whole in advising the board on these matters.

Training is another responsibility of the board of trustees. Some hospitals will be in a position to train medical students, interns, nurses, orderlies and technicians. Smaller hospitals will have less formal training programs; but hospitals, like individuals, must continually seek to broaden their horizons and to improve efficiency in all departments. Doctors will find this stimulus in the meetings of the medical staff. The administrator will provide the incentive and the methods for training the employees, and the board will find satisfaction in observing an alert group in constant search for better methods in dealing with the sick and injured.

In summary, the regularly constituted hospital board is charged under Provincial Statute with the responsibility for appointing and organizing a medical staff. The staff in turn, advises the board on medical policy, on new appointments, and supervises the quality of medical care given each patient in the hospital. The board stimulates training of both the medical and other groups in the hospital so that they may provide the most effective care of the individual patient. •



J. L. M. Anderson, M.D.,

*From an address presented at the annual meeting of the Royal Jubilee Hospital.*

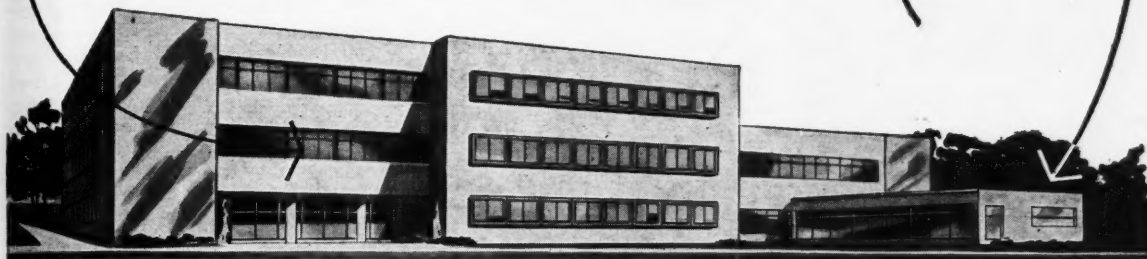
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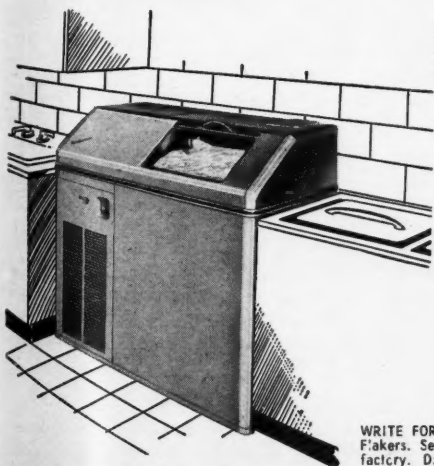


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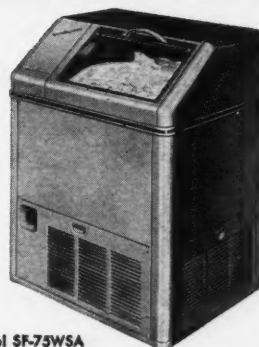
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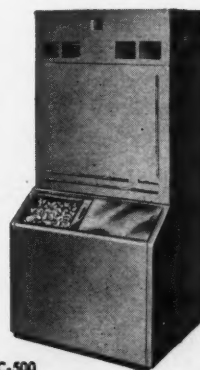
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## ◀ Provincial Notes ▶

### *British Columbia*

**INVERMERE.** The new Windermere District Hospital should be ready for occupancy next month. The 25-bed building was constructed at a cost of \$248,000. Architect is Paul Smith of Trail.

**KITIMAT.** The Canadian firm of Agnew, Craig and Peckham, hospital consultants, have proposed a 140-bed hospital for Kitimat. This is based on a working estimate of 5.5 beds per 1,000 population. A 275-bed hospital will be required at the final stage of Kitimat's growth and its accompanying population of 50,000.

**STEWART.** Tenders have been called for a new hospital to cost approximately \$70,000. The building is to hold nine beds with provision for extension. Architects are Whittaker and Wragg.

**SURREY.** A 63-bed hospital is to be commenced in the fall at an estimated cost of \$717,000. It is planned so that additions can be made, with proposed future expansion to a 300-bed institution. Architects are Gardiner, Thornton, Gathe & Associates, Vancouver.

**VANCOUVER.** A 34-bed private convalescent home planned here is to be known as Southpines Private Hospital. Initially, the building will measure about 105 by 40 feet. It is planned to add two 40 by 100-foot wings later, bringing total accommodation to 96 beds. Included will be eight private suites, a patients' lounge, staff dining room and the latest kitchen and service facilities. It was designed by Architect Murry Polson of Polson & Siddall, Vancouver.

**VICTORIA.** Plans for a 100-bed addition to Gorge Road Hospital are being considered. Present space and facilities for dietary service and heating could serve another 100 beds. The aim is a greater turnover of patients through segregation of long-term patients who could be rehabilitated and returned to their homes or nursing homes.

**WHITE ROCK.** A 40-bed addition to White Rock Hospital is proposed. Total capacity of the hospital will be brought to about 75 beds. Architects Robert C. Bennet Associates, Vancouver, expect authorization to commence working drawings for the single-storey frame addition some time this month.

### *Alberta*

**CALGARY.** The new nurses' residence at Holy Cross Hospital will cost approximately \$1,403,935. The eight-storey building will contain 256 rooms, in the six upper floors. Each floor will include a small kitchenette, lounge, and personal laundry for students. The complete building will be constructed of reinforced fire-proof concrete with walls of brick and tile.

**GRANDE PRAIRIE.** Feasibility of establishing a \$160,000 20-bed chronic convalescent hospital for the south Peace area at Grande Prairie was discussed recently. The hospital, if constructed, would be maintained as a separate unit, not as part of Pioneer Lodge, which operates as a home for the aged, nor would it operate as part of the Grande Prairie Municipal Hospital.

**SPIRIT RIVER.** Final phases of interior construction on the new \$350,000 addition to Spirit River's Holy Cross Hospital are currently underway. Already staff members and patients are using parts of the new structure. The new wing, of two-storey design, measures 60 by 110 feet, and is larger than the original hospital. When complete, the new structure will offer space for 49 adult patients and 14 children. Several new design features have been used in construction of the new building. One is the cement enamel sprayed onto the plaster walls, producing a permanent finish.

### *Saskatchewan*

**KAMSACK.** The Kamsack Union Hospital has recently completed the installation of new x-ray equipment. Rated at 500 Milliampères and with a ceiling tube-mount this equipment costs some \$18,000.

**MOOSE JAW.** A new 25-bed psychiatric wing is to be opened at Moose Jaw General Hospital this year and psychiatric services at the University Hospital in Saskatoon are to be extended, at a total cost of \$21,000. The Moose Jaw psychiatric wing will provide services similar to those given in the Munroe wing of the Regina General Hospital.

**URANIUM CITY.** The Uranium City Hospital and staff residence were officially opened recently by Hon. T. J. Bentley, Provincial Minister of Health. The single storey hospital of cement block and native stone construction will accommodate 25 patients in its 20,000 square feet of space. Staff residence is a two-storey building with accommodation for 23. The new hospital will serve the entire population of the Beaverlodge local development area at present estimated at 4,000 persons. There will be three physicians in attendance and the hospital is in charge of a trained administrator. The total cost of construction for the hospital and staff residence was approximately \$800,000 toward which the provincial and federal governments made grants totaling \$90,000.

**WEYBURN.** The new tuberculosis Annex building at the Saskatchewan Hospital is nearing completion. Construction was begun in the fall of 1954. The wing is a three-storey building with sun deck, and is about 183 feet long, with a width of approximately 35 feet.

### *Manitoba*

**GRANDVIEW.** Opened recently was the new Grandview General Hospital, built at a cost of \$140,000. Most of the old equipment is being transferred for use in the new 14-bed hospital.

**PORTAGE LA PRAIRIE.** The new hospital here is expected to be opened in July or August. The 80-bed structure is being built at a cost of \$50,000.

**PORTAGE LA PRAIRIE.** The new nurses' residence has been completed at the Manitoba Home for Mental Defectives here. A new unit for the hospital, designed to accommodate 180 female patients, will be completed in September. The nurses' home will accommodate 39 nurses required to care for the additional patients. Total cost of the nurses' residence was \$147,900.

(Continued on page 56)

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## Ontario

**AJAX.** The Ajax-Pickering General Hospital, which started out as temporary wartime buildings for a shell-filling plant, is to add another page to its already colourful career. By means of a 130-foot passageway between the hospital and the nurses' residence, 12 beds are to be added without putting up a new building.

**CAMPDEN.** Completion of the new wing at the Bethesda Home, a hospital for the mentally ill, has raised the capacity to 65. The addition also furnished more staff space and a new occupational therapy room.

**COLLINGWOOD.** A contract for the erection of a new wing for the women's ward and obstetrical department has been let by the Collingwood General and Marine Hospital Board. It is expected that the addition will be ready for occupancy this summer.

**DRYDEN.** Work on Dryden's new hospital commenced in May. The 50-bed institution, sitting atop a hill which overlooks Wabigoon Lake, will replace the old wooden structure in use for many years.

**KINGSTON.** Two of the three additional buildings for the Rockwood division of the Ontario Hospital are now under construction. The third, a 500-bed hospital, will not be ready for another three years. With its opening, Rockwood's division's capacity will be nearly doubled to a bed total of 1,200. Situated on the west end of the property, the two-storey brick hospital will stretch about 1,200 feet from the tip of one wing to the other, and will be approximately 300 feet at its widest point.

**NORTH BAY.** Superstructural steelwork is finished at the \$1,000,000 addition to St. Joseph's General Hospital. The new six-floor structure will house private and semi-private rooms and wards, with an increase of about 85 beds. Also contained in the new addition will be an operating room, x-ray suite, and laboratory. The hospital is owned and operated by the Sisters of St. Joseph.

**PARIS.** X-ray equipment has been purchased at a cost of \$9,500 for the Willett Hospital. The new equipment

will aid in diagnosis and treatment.

**PICTON.** A new 50-bed Memorial Hospital is to replace the present 28-bed institution which is proving inadequate to serve the needs of Prince Edward County. Plans have been drawn up by Dreever and Smith of Kingston. It is not expected that any definite action will be taken until September.

**PORT ARTHUR.** Plans are nearing completion for further additions to patient and staff accommodation at the Ontario Hospital, costing almost \$2,000,000. Construction work on it is to be started this summer.

**PORT CREDIT.** Work will commence this month on the five-storey, 125-bed South Peel hospital costing approximately \$1,186,307. This includes the price of a diesel auxiliary power plant for use in case of hydro failures. The completion date is set for October 1st, 1957.

**PORT HOPE.** Construction will begin this fall on a new \$300,000 wing for the Port Hope Hospital. Bed capacity will be increased from 45 to 66, and eventually 100. Most of the rooms in the new wing will be private or semi-private. Improved obstetrical services, doctors' lounge and library, and out-patient facilities will be features of the building.

**SCARBOROUGH.** The new Scarborough General Hospital was blessed by Cardinal McGuigan recently. The hospital is under the direction of the Sisters of Misericorde and was officially opened last month by Hon. Dana Porter, provincial treasurer.

**SOUTH PEEL.** A mass sod-turning ceremony began work on the 125-bed South Peel County Hospital as 44 children, one from each school in Port Credit, Toronto Township, and Streetsville turned a spadeful of earth. Each pupil received a miniature silver spade as a memento. The \$1,750,000 hospital on Highway 10, south of Cooksville, will be in operation by October of 1957.

**TORONTO.** Construction of the Queensway General Hospital and nurses' residence is almost complete. All facilities should be available by July 31. There will be accommodation for 140 patients and it can be enlarged to take care of 400 patients.

**TORONTO.** A new \$5,300,000 hospital and rehabilitation centre is plan-

ned for the Workmen's Compensation Board of Ontario, on a site within metropolitan Toronto. The new buildings, to house 500 patients, will operate on funds from employers and employees. The hospital and grounds will occupy 15 acres.

**TORONTO.** By next January a new \$1,400,000 hospital will be serving the needs of 200,000 North York residents. First major hospital in the township, it is named after William H. Branson, former world secretary of the Seventh Day Adventists. This church, which has 235 hospitals throughout the world, has been working on North York Branson Hospital for five years. The 100-bed hospital is being built on a 25-acre site overlooking the Don River.

## Quebec

**MONTREAL.** Construction of two five-storey wings to accommodate the nurses and attending sisters of St. Mary's Hospital is expected to begin shortly. Part of the hospital's \$5,500,000 expansion program, for which funds were solicited last spring, the buildings will include new laboratories for the sciences, dietetics and nursing arts, new classrooms, a library, recreation hall, nurses' living quarters, and offices for instructors. The institution was founded in 1925 and has been in operation at its present site since 1934. It now accommodates 234 beds and a nursery for 45 babies.

**MONTREAL.** The Jewish Hospital of Hope for chronic diseases will open a new \$350,000 wing next autumn. It will have a modern occupational therapy department and other rehabilitation facilities, a surgery department, a larger pharmacy, an auditorium and increased x-ray equipment. At present 80 patients are being cared for at the hospital.

## New Brunswick

**CHATHAM.** More than 400 visitors of the Miramichi area attended the breaking-ground ceremony for the new addition to Hôtel Dieu de St. Joseph. The history of the institution from its inception in July 1869 to the present day was recounted, and the Chairman of the Board pledged their support and co-operation for the welfare of the hospital. Costing \$700,000, it is to contain 34 beds and space for x-ray and other equipment.

(Concluded on page 100)

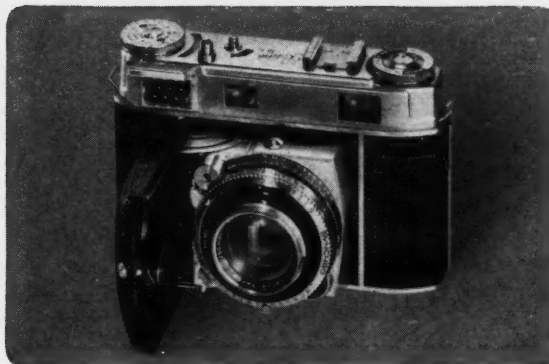
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#### University of Toronto Students in Hospital Administration

Shown here are the 1955-56 students and members of the staff, Department of Hospital Administration, School of Hygiene, University of Toronto. Having completed the academic year of this post-graduate course, the students will spend the next 12 months in administrative residencies at hospitals in Canada or the United States where arrangements have been made for their further instruction.

In the back row, from the left: Clarence R. Horton, Murray, Kentucky; Dr. G. Dudley Barnett, Fort San, Sask.; Vernon E. Dressler, Torquay, Sask.; Moshe Katz, Toronto; and George A. Miller, New York, N.Y.

Centre, left to right: William B. Beatty, Halifax, N.S.; W. Ben Stephaniuk, Weyburn, Sask.; Dr. Victor H. Radoux, Quebec, P.Q.; and Hugh R. McGann, Vancouver, B.C.

In the front row are members of the staff: Harold G. Dillon, Research Fellow; Eugenie M. Stuart, Associate Professor; Dr. Harvey Agnew, Professor and Director; and Dr. W. Douglas Piercey, Assistant Professor.

#### Council No. 11, O.H.A., Holds Regional Meeting

St. Joseph's Hospital, Sudbury, was host to Council No. 11 of the Ontario Hospital Association for a regional meeting Thursday, May 17th. Some 50 delegates attended. Following invocation by Rev. Father L. Mailhot, s.j., chaplain of St. Joseph's Hospital, and a welcome to the delegates by Harry Waisberg, Q.C., chairman of the board of the hospital, Mr. R. J. Long, administrator of the North Bay Civic Hospital and president of Council No. 11, addressed the meeting.

After a short business session, Sister Françoise-de-Chantal, director of nursing of St. Joseph's Hospital, gave an interesting and informative paper on "Responsibilities of Director of Nursing Services". This was followed by a question and answer period. Following luncheon at St. Joseph's Hospital, Dr. W. Douglas Piercey, executive director of the Canadian Hospital Association, outlined provincial hospital insurance plans now operating in Canada. Mr. S. W. Martin, associate executive secretary-treasurer of the Ontario

Hospital Association, spoke on "Hospitals and Hospital Insurance" as it pertained to Ontario.

The following officers were elected for the ensuing year: president, Sister St. Camillus, assistant administrator, St. Joseph's General Hospital, North Bay; vice-president, Dr. C. J. Doherty, administrator, The Sudbury-Algonia Sanatorium, Sudbury.

#### New Two-Year Course For Student Nurses

Closer integration of academic and clinical studies, and elimination of duties some students consider drudgery, are highlights of a revised course in nursing at the Toronto General Hospital and its Wellesley division.

Under the new curriculum and program of teaching, students will go on salary at the end of two years when they write examinations to qualify as registered nurses. During the third year of the course, known as internship, they will be given greater opportunity to serve at patients' bed-

sides, after which they will receive diplomas and certificates of registration. A tuition fee of \$50 will be charged on entrance to the course and again at the beginning of the second year. In addition the student must supply her own books and uniforms. At the beginning of the third year, the period of greater service in the hospital, the girls will receive a monthly salary of \$130, and will assume the cost of their lodging, which need not be in residence. They will also continue to provide their own uniforms and other requirements. The program will come into effect this September with the enrollment of 120 students at the Toronto General's school and 50 at the Wellesley school.

Requirements for acceptance of students remain as they have been in the past, with a minimum of junior matriculation as the provincial standard set by law in addition to the individual hospital's special requirements.

One may be humble out of pride.—*Montaigne.*

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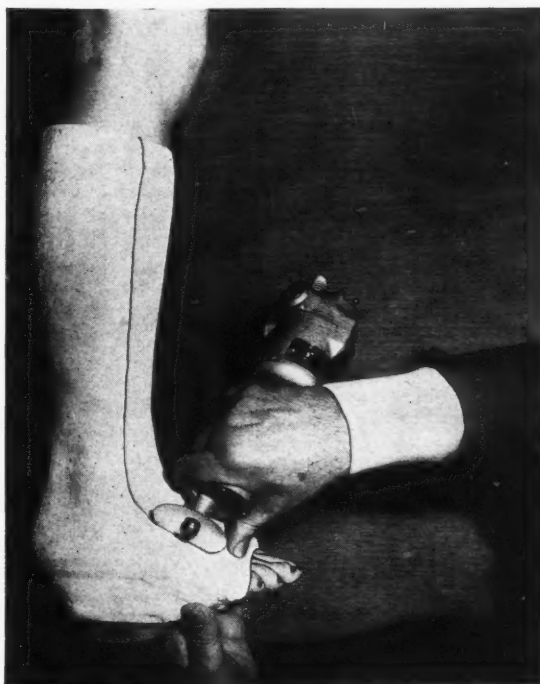
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# With the Auxiliaries

## Auxiliary Members Called Goodwill Ambassadors

At the fourth annual convention of the Province of Quebec Association of Hospital Auxiliaries, held recently in Montreal, P.Q., Raymond P. Sloan, editorial director of *Modern Hospital*, emphasized that members of hospital auxiliaries should be ambassadors of goodwill. "It has long been hospital tradition to make life as diverting as possible for the youngsters in our children's wards. We are beginning now to recognize the importance of doing something for the adult who, upon entering the hospital as a patient, assumes many of the characteristics of a child — all the fears, the uncertainties, the instinctive groping for maternal or paternal reassurance."

"Education of the public is a vital part of the hospital auxiliary's role," said Dr. Gerald LaSalle, M.D., administrator of the University of Montreal Hospital, at the same meeting. "To be successful, you must make it your job to find out precisely what goes on in the hospital and why certain tasks are done. You must know the history of hospitals and the magnificent progress of the past 25 or 50 years. You should be familiar with the reasons that explain the high cost of hospital services on one hand and also the incomparable superiority of services offered on the other hand. Finally, you should be aware of the services rendered to the community by the hospital in the field of education (medical, nursing and other allied fields), in the field of research and of public health in general. . . . All people have various strengths, although some are too humble and modest to realize them. Care enough about your members to learn more about each individual, to unearth her qualities."

The 33 auxiliaries of Quebec province, represented in this association, have a total of 17,000 members. They have raised, during the past year, nearly \$350,000 which they have donated for equipment.

• • • • •

## Annual Tea

The Women's Hospital Auxiliary to Ottawa General Hospital, Ottawa, Ontario, recently held a successful tea, with many from Ottawa, Hull and the surrounding regions attending, in spite

of poor weather conditions. It lasted from 4 until 7 o'clock, finishing with a draw for several donated articles, among which were a beautiful coffee table, and a tooled leather purse.

• • • • •

## Earns \$66,630 in Eight Years

A cheque for \$9,000 was given during the past year to the board of management of the Lachine General Hospital, Montreal, P.Q., establishing a fund known as "The Women's Auxiliary Equipment Grant", from which each hospital department benefitted. The good-as-new shop brought in \$5,713. More than 2,000 new articles were acquired including 125 new uniforms for use in all departments. Since the auxiliary's re-organization eight years ago, total earnings amount to \$66,630, which does not include hundreds of dollars worth of gifts made directly to the hospital by associated groups. The auxiliary has 1,235 members. Soon to be purchased by them are a number of deluxe bassinets at a cost of about \$200 each, and an infra-red lamp and diathermy machine costing about \$900.

• • • • •

## Cubicle Screening Purchased

The Ladies' Aid to the Kenora General Hospital, Kenora, Ontario, spent \$1,400 on cubicle screening, to provide privacy for patients, in 1955; and \$114 was spent on goose neck lamps. Lamp shades, mirrors and curtains were also bought. The Ladies' Aid was able to accomplish this only through the generous support of the citizens of Kenora, Keewatin, and district. In all, disbursements for essential supplies bought by the Ladies' Aid for the hospital amounted to \$4,300 in the past year.

• • • • •

## Old Black Magic

Turning rags into riches for the benefit of Winnipeg General Hospital, Winnipeg, Manitoba, has become an annual affair for the White Cross Guild. In the six drives already conducted the Guild has raised \$52,373, having collected 867,477 pounds of rags. All cottons, such as old tablecloths, shirts, sheets, smocks, dresses; knitted goods, including socks, sweaters, scarves, gloves, as well as woven suits, dresses, overcoats, slacks, snow suits, and ski pants, are all valuable

for the "rags to riches" drive. Turning old rags into dollars for the hospital has provided the following: equipment for operating rooms, neuro-surgery, bone-bank, baby respirator, scales, wheel chair; \$12,000 to the building fund to equip a casualty ward; washing machine, refrigerator, hair dryer, furnishings for the lounge for nurses; for the patients, a mobile library, hair-dressing, shopping services, handicrafts instruction, special ward service, baby photography; for out-patients, financial assistance to the social service department to provide medical supplies, surgical supports, eye glasses and other items.

• • • • •

## Successful Financial Year

The annual report of the Women's Auxiliary to the Montreal General Hospital, Montreal, P.Q., showed total receipts for the year of \$33,675 realized from fees, branch money-raising and the revenue from Hospitality Corner, the auxiliary's gift shop and snack bar. The Memorial Fund received \$4,154. These donations, made in memory of friends or relatives, are used to provide life-giving or life-sustaining equipment for the hospital. This year the auxiliary plans to supply voluntary workers in the hospital, to help supply reading matter, to get a travelling shop underway for the use of patients, to supply driving service transportation for patients, to sew for the hospital and provide cookies at the snack bar and articles for the gift shop.

• • • • •

## Diathermy Machines Purchased

The Eckville Municipal Hospital Women's Auxiliary Eckville, Alberta, has purchased a new diathermy machine. This project was first thought of as a long term one, but now, after less than six months, the unit is set up, owing to the wonderful support of the district and to special donations. The hospital auxiliary to Whitewood Community Hospital, Whitewood, Saskatchewan, has also decided to buy one of these machines, which increase the temperature of the tissue beneath the skin by applying high frequency currents to the surface.

• • • • •

## Direct Link with Patients Important

At the annual meeting of the auxiliary to Shaughnessy Veterans' Hospital, Vancouver, B.C., it was stressed that visiting is a vital link with the world for the patient. Two visitors from this auxiliary go to each ward, and carts are filled with treats to be distributed.

(Concluded on page 62)

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## Auxiliary Notes

(Concluded from page 60)

Some of the money spent on this work came from the group's Carousel last summer which put \$5,003 into the treasury. Their station wagon was busy last year, driving more than 6,500 miles, and taking patients out for pleasure drives 136 times. The wishing well in the Garden of Remembrance added \$467 to the auxiliary funds.

### Outstanding Year

The Women's Auxiliary to the Prince Rupert General Hospital, Prince Rupert, B.C., had a very profitable year. Through raffles, bake sales, rummage sale, two teas and the sale of cook books, the auxiliary raised \$2,397 during 1955. Compiling a cook book was the highlight of the year's work. While the printing of it necessitated a tremendous outlay of money a very substantial increase in annual income is anticipated through its sale. From the 2,000 copies ordered it is hoped to make a profit of \$2,400. Among many other activities, three nights a week these members read stories to the children in the hospital.

### Many Articles Provided

The Ladies' Auxiliary to the McKellar General Hospital, Port Arthur, Ontario, have decided to purchase 36 bed lamps for the new wing to their hospital, nine dozen women's chenille bathrobes and 18 dozen children's terry cloth bathrobes at an approximate cost of \$2,000. Several dozen pairs of sock savers and four layettes have recently been bought and also one floor lamp, one special spread, and two pictures were obtained for the private room on the obstetrical floor.

### Auxiliary Donates \$2,800

The Women's Auxiliary to Humber Memorial Hospital, Weston, near Toronto, Ontario, recently presented cheques amounting to \$2,800 to the board of governors. The sum of \$1,700 is to complete the three-year pledge of the auxiliary to the expansion fund. The other cheque is for \$1,100, to be used for replacing drapes in the original hospital rooms.

### Busy Auxiliary Fills Needs

During the past year, the Women's Auxiliary to Enderby and District Memorial Hospital, Enderby, B.C., have been busy supplying many needed ar-

ticles to the hospital. Some of these were two electric ranges, a number of spring-filled mattresses, an electric toaster and an electric mixer. Cups and saucers and other tray needs were also supplied.

### Group to Buy "Walker"

The Women's Auxiliary to Kitchen-Waterloo Hospital, Kitchener, Ontario, will purchase a "walker" for the use of patients at Kathleen Scott Pavilion. It will cost approximately \$100. Volunteer drivers have been called on to "let patients get a breath of spring air." A donation of \$100 was made to the nurses' residence.

### Instrument Washer-sterilizer

The Women's Auxiliary to the Nanaimo General Hospital, Nanaimo, B.C., has given \$1,000 toward the cost of a new instrument washer-sterilizer. They also report that the cooking school held in March realized a profit of \$212.

### Changes Made

The Ladies Auxiliary to Hanna Municipal Hospital, Hanna, Alberta, added a new oxygen tent and a new folding wheel chair to the hospital equipment recently. Larger cribs have been set up in the children's ward, sound-proof doors have been installed, and more home-like surroundings have been created, through the efforts of the auxiliary.

### An Eye to the Future

The Junior Hospital Auxiliary to Kelowna General Hospital, Kelowna, B.C., has decided to set aside annually a \$500 bond for furnishings for a new hospital wing which is planned. It was also decided to buy equipment costing approximately \$1,000.

### Wagon Shop Busy

The Women's Auxiliary to Brockville General Hospital, Brockville, Ontario, have found their wagon shop a popular and demanding undertaking. They sell cigarettes, candy, toys, aprons, baby clothes, dolls and many other articles which are all part of the shop's regular stock. The canteen served 7,577 cups of coffee during its first five months of operation.

### Statistics Show That . . .

A small attendance at annual meetings does not necessarily mean that there is a lack of interest in the work

of the group. For instance, we note that only 11 members attended the annual meeting of the Ladies' Hospital Auxiliary of the County of Bruce General Hospital, Walkerton, Ontario, yet they started last year with a bank balance of some \$1,500 and raised over \$1,300 during the year. In addition to donating six pairs of curtains and curtain rods for the ward rooms, plus a heavy duty mixer and 6 bowls for the kitchen, and other items, they donated \$1,000 toward the setting up of a laboratory and \$300 for the purchase of linens.

### Purchase Over-bed Tables

Over-bed tables for patients at Royal Jubilee Hospital, Victoria, B.C., will be purchased with the sum of \$1,200 which was voted to the hospital at a recent meeting of the Women's Auxiliary.

### New Attraction

A spacious gift booth has been added to the lobby of South Waterloo Memorial Hospital, Galt, Ontario, by the Women's Auxiliary. Members of the auxiliary will operate it during hospital visiting hours.

### Auxiliary Promises \$20,000 Gift

The Oakville-Trafalgar Memorial Hospital Women's Auxiliary, Oakville, Ont., has pledged the sum of \$20,000 to be used preferably for furnishing the new gift shop and canteen for that hospital. Payment will be extended over a five-year period if necessary.

### Costly Equipment Purchased

The Women's Auxiliary to the Prince George and District Hospital, Prince George, B.C., contributed \$2,615 to buy equipment for the hospital during the past year. In addition, an ice maker purchased by the auxiliary cost \$571 and \$613 was spent for four bassinets with baskets and mattresses for the future maternity ward addition, and for one incubator with humidifier.

### Electrically-Heated Food Carts

The Ladies' Auxiliary to St. Joseph's Hospital, Chatham, Ontario, have completed payments on electrically-heated food carts for each floor of the Hospital. Their project for 1956 is the purchase of a much-needed ice machine and more laboratory equipment. An important source of income is the annual penny sale for which plans are being made at present. ●

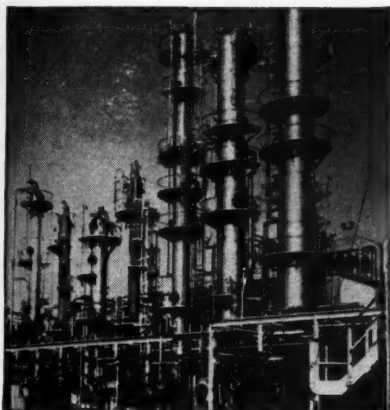
## G. H. WOOD CLOSES EXCLUSIVE DEAL

### A Boon to Better Cleaning is Born

An amazing all-purpose liquid detergent called 'Teepol' is now being marketed across Canada by G. H. Wood & Company, Limited—the 'Sanitation For The Nation' people.

### 'Teepol' is a Good Mixer

Laboratory tests show that 'Teepol' mixes equally well with hard, soft or even salt water, and being neutral, is miscible in either alkaline or acid solutions over a wide pH range making it adaptable for numerous Industrial Processes.



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The wetting and detergent action of 'Teepol' is amazingly fast. Dirt is lifted from the surface and held in solution, and quickly rinses away . . . leaving a clean scum-free and non-streaky surface.

### Scientific Sanitary Cleaning

'Teepol' assures tremendous time and labour saving improvements in general cleaning, its amazing fast action gets the work done quicker, better and at *much less cost*.

Maintenance Superintendents of hospitals, schools, office buildings, hotels, factories and wherever sanitation maintenance is required, find that 'Teepol' is the one product that can be effectively used for *all* their cleaning. 'Teepol' always cleans to a sparkling finish and can be used on anything washable.

### Textile Processing

'Teepol' is recommended for its good detergent effect and good stability with hard water and most of the chemicals normally employed in textile processing.

Even the Cosmetic and Toiletry Industries use it as a base for many of their products.

### Special Aid in Metallurgy

'Teepol' is used in various processes in the engineering and metallurgical industries, it is highly recommended for aqueous degreasing either through immersion, drum washing, spraying or electrolytic methods.

'Teepol's' amazing wetting properties together with certain specified additive agents contributes to the economical and efficient cleaning of non-ferrous metals.



### A Thousand Technical Uses . . .

There are many uses for 'Teepol' wherever water is used in manufacturing processes. It performs exceedingly well as a detergent, wetting agent, dispersant, foaming agent, penetrant and emulsifier.

### Continual Laboratory Research

Paul J. Ammann, Wood's Director of Chemical Research, says there are scores of Industries where the unique properties of 'Teepol' can be used to advantage. He points out that his Laboratories are continually testing new uses for 'Teepol'.

### Control Cleaning of Food Equipment

'Teepol' is of particular value in the Food Industry where high standards of cleanliness are essential. It is very effective in the washing of bottles, glassware, aluminum, stainless steel and other non-ferrous metal equipment.

### Try It —Free

A G. H. Wood Representative will be pleased to demonstrate on your premises the many advantages of 'Teepol', without any obligation whatsoever. A note or phone call to Wood's nearest office will receive prompt attention.

### 'Teepol'—Master Detergent

'Teepol' has been awarded the Certificate of the Royal Institute of Public Health and Hygiene.



PAUL J. AMMANN  
Chemical Research Director

### Some Industrial Uses

For example—Ammann says:— " 'Teepol' is being used as a foaming agent in the production of cellular concrete and in various processing in the Engineering and Metal Industries. The Leather and Fur Trade find the wetting, dispersing and emulsifying properties of 'Teepol' very useful. 'Teepol' is used by Paper Mills in various pulping processes and for cleaning woollen felts."

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Hospital Management find that 'Teepol' is an excellent and hygienically sound General Service Cleaner and a real help in maintaining traditional cleanliness.

You can specify 'Teepol' with the assurance that any surface you can wash down with water—you can clean better—quicker—and at lower cost with 'Teepol'.

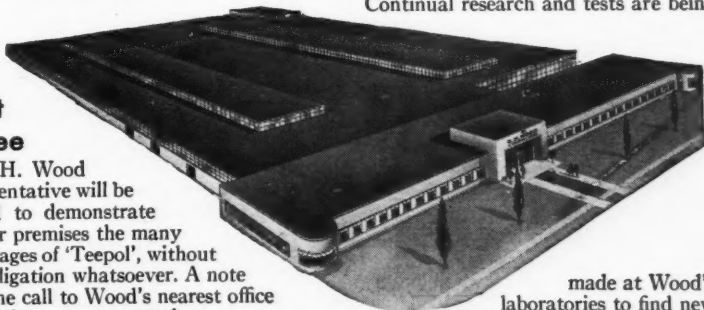
'Teepol', the Master Detergent, is amazingly versatile—use it on Rubber, Mastic, Asphalt and Vinyl Tile, Terrazzo, Linoleum and Conductive Flooring . . . as well as for painted and enamelled surfaces, carpeted floors, windows, woodwork and sealed wooden floors.

'Teepol' is wonderfully effective when used in kitchens or wherever food is processed or served. Bathroom fixtures, tiled surfaces are cleaned to a sparkling finish with 'Teepol'.

Use 'Teepol' to clean rubber gloves and surgical instruments—effectively and quickly—prior to autoclaving.

### Where 'Teepol' is Processed

Continual research and tests are being



made at Wood's laboratories to find new uses for 'Teepol'. Readers should contact the G. H. Wood & Company, Limited, at Toronto, Montreal or Vancouver—or at any of their branches at major centres across Canada for further information on this very diversified product.

## ◀ Book Reviews ▶

**MALPRACTICE LIABILITY OF DOCTORS AND HOSPITALS** (Common law and Quebec law). By William C. J. Meredith, Q.C., Law Tripos, Honours; Cambridge; Member of the Bar of the Province of Quebec; Dean of the Faculty of Law, McGill University. With a foreword by J. Gilbert Turner, M.D., Executive Director, Royal Victoria Hospital, and President, Canadian Hospital Association. Price \$7.75. Pp. 315. Published by the Carswell Co., Ltd., Toronto, Ont., 1956.

This volume deals with the following subjects: (1) relations between doctor and patient in general; (2) professional secrecy; (3) the doctor as a witness; (4) malpractice in diagnosis and treatment; (5) liability of hospitals; (6) civil courts and procedures; (7) assessment of damages in bodily and fatal injury cases; and (8) criminal malpractice.

Chapter 5 is of special interest. The topics discussed include: responsibility as to appliances; preparation and handling of drugs; responsibility for doctors, interns and nurses in the hospital's employ; responsibility for doctors not in hospital's employ; responsibility for interns and nurses under direction of third parties; responsibility for special nurses; consent for operations and other treatments, photographs, et cetera; patients of unsound mind; unconscious patients; emergency operations; disclosure to patient; unauthorized extension of surgery; consent to additional or alternative surgery; forms of consent to operation; refusal to submit to treatment; refusal followed by emergency; autopsies; right of executors; suicides and attempted suicides; hospital records; and patients' wills. These read like a list of day-to-day problems and, indeed, they are, because all of them have bothered every administrator on some occasion.

In the foreword, Dr. Turner states, in part: "Mr. W. C. J. Meredith, Q.C., has done an outstanding service to all interested in patient care by writing this excellent book. Very frequently members of the medical profession and hospital executives are confronted with problems having medico-legal implications, and in many instances these are very embarrassing moments because a good knowledge of leading rules and principles on malpractice liability is not immediately available. Now for the first time in Canada we have a book which will give us that knowledge. The text is intended to be intelligible to laymen and is almost free from

legal technicalities. . . . A welcome feature of the book is that it is short yet it covers Quebec as well as the Common Law jurisdictions. A substantial portion of the material is also applicable in England and the United States. A glance at the chapter titles provokes immediate interest. The reader will find that this interest is fully maintained throughout the text. It is a book which should be owned and studied by every medical practitioner, by every hospital executive, and by every lawyer who is interested in medico-legal problems of medical practice and hospital administration."

Having read this book, I can concur heartily with Dr. Turner's assessment. It is a book for which there has been a long-felt need in Canada. — W. D. P.

**LAW AND THE PRACTICE OF MEDICINE.** By K. G. Gray, M.D., Q.C., lecturer in medical jurisprudence and forensic psychiatry at the University of Toronto. Second edition. Pp. 133. Price \$3.25. Published by Ryerson Press, Toronto, Ont.

Published originally in 1947, Dr. Gray's earlier book on the same subject was a small volume of some 68 pages based upon his lectures to medical students. As legal advisor to the Ontario Department of Health, the author found it necessary to consider many aspects of the law as it relates to medical practitioners and hospitals and that experience lent value to his book. For some time the volume has been out of print and there has been genuine need for further guidance on this subject. Inquiries and comments from doctors and lawyers have encouraged the author to undertake a substantial enlargement of the contents for the second edition. In the intervening years the law governing some of the topics has been clarified and every effort has been made to incorporate all such changes in the revision. He states the law as it applies throughout Canada and directs the reader's attention to provincial variations.

Of special interest is the enlarged section on "Doctor, Nurse, Hospital, in Actions of Negligence" which cites many recent decisions. Subjects dealt with here which were not included in the first issue are: production and inspection of medical and hospital records; special procedures; mental ill-

ness; mental illness in criminal cases; amnesia; and sex offenders.

Dr. Gray's book is not for physicians only. It should be studied and kept in the library of every hospital administrator. Recommended reading for students in hospital administration.

**STUDIES IN THE FUNCTIONS AND DESIGN OF HOSPITALS.** By Nuffield Provincial Hospitals Trust. The report of an investigation sponsored by the Nuffield Provincial Hospitals Trust and the University of Bristol. Pp. 212. Illustrated. Price \$9.50. Published by Oxford University Press, London, New York and Toronto, 1955.

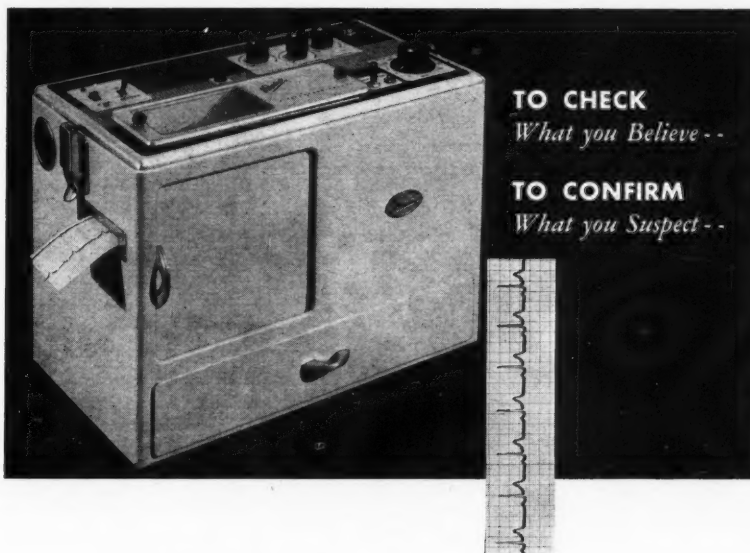
This is an account of five years' practical and theoretical research into the design of various departments in general hospitals, and into the ways of organizing work in them. The investigation was sponsored jointly by the Nuffield Provincial Hospitals Trust and the University of Bristol, and the members of the team were deliberately chosen from diverse professions to include a doctor, a nurse, architects, an historian, and field workers. The approach has been predominantly architectural. The contents are arranged under seven main headings: (1) the ward; (2) the out-patient service; (3) the operating theatre; (4) the physical environment in the hospital; (5) fire protection in hospital; (6) some general considerations affecting design; and (7) planning to meet demand.

The study is based on original research concerning various aspects of the general hospital. It deals primarily with British hospitals, although U.S. Public Health Service recommendations are used for comparison in some instances. A study team, under the direction of Richard Llewelyn Davies, considered the ward unit in six different types of hospitals and made comparisons as to the use of space and the provision of facilities. Original designs are recommended. Many time and motion studies were made and the results are set forth in charts as well as text.

The chapter on out-patient service is highly valuable. In England (since 1930) patients come to the out-patient clinic by appointment; some excellent time and motion studies were made as to what happens after they arrive at the clinic. Graphs are presented showing the percentage of patients that arrive early, on time, and late for their appointments. Also shown graphically are tables for the attending staff's punctuality. The correlation of these two graphs is very interesting.

In equating this book to Canadian

*(Concluded on page 78)*



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*What you Believe - -*

**TO CONFIRM**  
*What you Suspect - -*

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## Notes on Federal Grants

### Construction

In Victoria, B.C., a grant of \$10,500 goes to the Royal Jubilee Hospital to assist in financing the cost of an addition to their psychiatric unit.

Grants totaling \$144,000 have been awarded to Alberta to assist in the expansion plans of Rosehaven Hospital, Camrose, where a grant of \$75,000 goes towards construction costs of a new frame and stucco building to provide additional accommodation for patients. The new building will house two wings of 25 beds each, with a dining room, day rooms, and other facilities. A second grant, for \$69,000 will help to pay the costs of a new dormitory addition with accommodation for 46 patients and related facilities.

Manitoba is to receive \$26,300 to assist in the construction of a central laboratory for the province to be built as an addition to the existing medical college building, adjacent to the Winnipeg General Hospital. Scheduled for completion in July of this year, the new unit will serve the entire province and act as a consulting or reference laboratory for other hospitals and branch laboratories operated by the province.

A total of \$290,000 for hospital construction projects in Ontario will assist in providing additional hospital beds, nurses' accommodation, community health centres and other facilities. A large grant of \$116,456 goes to Humber Memorial Hospital, Weston. The grant will contribute to the establishment of 64 additional active treatment beds, ten recovery and seven labour beds, 40 bassinets, 6,637 square feet of floor space for community health centre facilities and, generally, improve the hospital's medical, surgical and obstetrical services. New construction calls for change of a nursery into paediatric wards, establishment of a laboratory and an enlarged surgical suite in what was formerly a delivery suite.

Almost as large an amount goes to the Sydenham District Hospital, Wallaceburg, with approval of \$94,450 towards construction to give that institution 77 new active treatment beds, two labour beds, 24 bassinets and out-patient facilities.

Grants were also approved for \$24,000 to the Queensway General Hospital, Toronto, to assist in construction of a nurses' residence, with ac-

commodation for 48 nurses; \$22,800 to St. Joseph's Hospital, London, to make space available for out-patient facilities; \$10,160 to the Civic Hospital, Ottawa, to enable the hospital to provide space for out-patient services, including an addition to the radioisotope laboratory and cobalt therapy unit; \$9,000 to the Royal Victoria Hospital, Barrie, to provide space for 18 nurses' beds; \$6,000 to assist in establishing 12 nurses' beds at the Haldimand War Memorial Hospital, Dunnville; \$4,273 to St. Joseph's Hospital, Hamilton, to assist with the cost of alterations for a new physiotherapy department; and \$3,125 to St. Vincent's Hospital, Ottawa, to provide additional accommodation for 10 nurses.

### Research

New research projects dealing with various aspects of child and maternal health in British Columbia are to get federal assistance. A grant of \$7,488 goes to the British Columbia Medical Research Institute for a study of the incidence and the relationships of the various factors responsible for staphylococcal infections. The study will be carried out at the Research Institute under Dr. A. F. Hardyment of the Paediatrics Department, Vancouver General Hospital.

A grant of \$2,100 has been awarded to the University of British Columbia medical faculty for studies on the morbidity of both mother and foetus during pregnancy. The project will be undertaken by Dr. Alec M. Agnew, head of the department of obstetrics and gynaecology, U.B.C. In the course of the project a detailed study of maternal deaths will be made to assess the circumstances surrounding them and to assess whether deaths could be classified as preventable or otherwise. The research will be carried out in close collaboration between U.B.C., the provincial health department and the committee on maternal welfare of the B.C. division of the Canadian Medical Association.

A third grant, one for \$6,000, will be used for research in the blood levels of adrenal gland steroids and their effect on resistance to disease. The results of the study, to be undertaken by Dr. F. E. Bryans, department of obstetrics and gynaecology, U.B.C. are expected to help in reducing the pre-natal foetal mortality rate.

Three new federal grants for mental health research at the University of British Columbia have been awarded. A grant of \$13,577 will be used for research in metabolism of the body during schizophrenia. The project will be carried out under the direction of Dr. W. C. Gibson, professor of neurological research, U.B.C., and is expected to take from two to three years. Also, a grant of \$12,271 will be used for research into the present methods of treatment of mental disease on the structure of the brain. It is expected that information gained from this study will be of considerable value in formulating and using treatment procedures for the mentally ill. A third grant to U.B.C., one for \$8,673, will be used for a survey of the causative factors in mental deficiency and will be carried out at the Woodlands School, New Westminster. It is hoped that the survey will pinpoint future needs in the field of mental deficiency and assist with the problems of classification and rehabilitation of mentally deficient persons. Both of these projects will be carried out under the direction of Dr. W. C. Gibson.

### Public Health

An experimental health project in Alberta for the oxygen replenishment of polluted streams is to get a federal public health grant of \$10,125. The purpose of the project, which got underway before the ice break-up, is to carry out research in an experimental area of the North Saskatchewan River as a further means of control in the abatement of pollution difficulties which have occurred during periods of ice cover downstream in the river. Sanitary engineering officials doing the research hope that by replenishing the supply of oxygen, the decomposition of polluting materials will proceed normally and that the odours which have developed in the river water in the absence of oxygen will be reduced to acceptable limits.

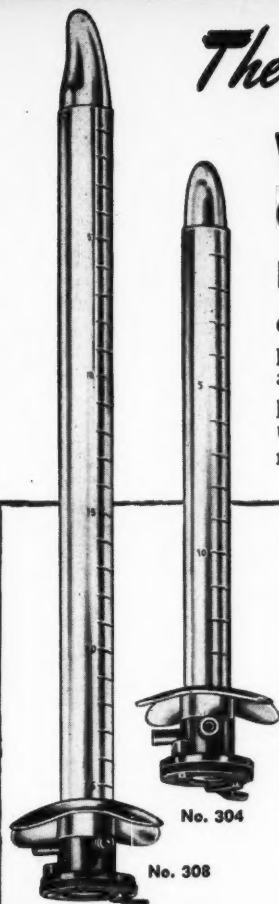
In Ontario, the University of Ottawa gets a grant of \$3,800 to carry out a study of staphylococcal toxin in relation to the pathology and serious effect of staphylococcal pneumonia in infancy. The study will be directed by Dr. J. Gibbons, professor of bacteriology, and Dr. Desmond Magner, professor of pathology. In Kingston, a grant of \$5,116 will be used at Queen's University for fundamental studies of the human placenta to provide greater knowledge of the causes of stillbirths and methods of preventing them. The study will be directed by Dr. Robert I. Merritt of the department of obstetrics and gynaecology.

Toronto's Hospital for Sick Children gets a grant of \$12,208 for research  
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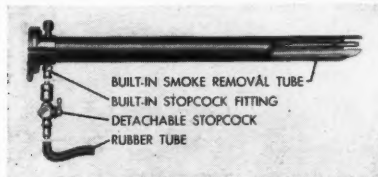
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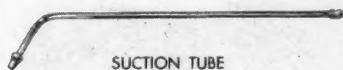
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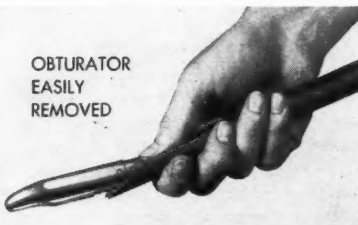
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## THE STEVENS COMPANIES

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(Concluded from page 68)

in abnormal pulmonary ventilation in the newborn. The study is to be supervised by Dr. Charles E. Snelling, senior physician at the hospital. A previous study undertaken by Dr. Snelling disclosed that respiratory disorders are the leading cause of death in live born infants. It is hoped that the new research will help to bring about a reduction in the mortality rate in the early infancy period.

Two Montreal hospitals are to receive federal financial assistance for special projects involving cancer control and medical rehabilitation. The Jewish General Hospital will receive a grant of \$6,286 to help provide additional technical equipment and staff for the hospital cancer clinic. A grant of \$12,499 goes to the Royal Victoria Hospital to assist in setting up a rehabilitation service. Plans have been made to use some 40 beds for this centre. Included will be the departments of physiotherapy, occupational therapy and speech therapy. Social service workers are also expected to take part in the program, which will be closely related to those of the Rehabilitation

Centre of Montreal and the faculty of medicine, McGill University.

Research on the effects of exposure to radioactive strontium is the purpose of an \$8,000 grant to the Department of Experimental Surgery, McGill University. The research is being directed by Dr. Donald R. Webster and is closely allied to the federal health department's studies of the radiation background.

At the Royal Edward Laurentian Hospital a grant of \$4,535 goes towards research into new aspects of tuberculosis control. The study is being supervised by Dr. Edith Maniewicz, bacteriologist in the Royal Edward's laboratories.

A child and maternal health grant to Montreal Children's Hospital of \$4,950 will be used for research on blood clotting factors in premature and full-term newborn infants. It is hoped that a comprehensive study of the blood clotting factors may bring to light some of the causes of bleeding in both premature newborn infants and newborn infants. The study will be carried out by Dr. R. Goudreau under the direction of Dr. R. L. Denton.

A federal research grant for a diagnostic study of neurotropic virus diseases in the four Atlantic Provinces is one of three new health grants for the Maritimes. The study planned under the grant represents a clinical and laboratory investigation of neurotropic diseases prevalent in the Atlantic provinces. Since vaccination against polio has been introduced, a number of clinical symptoms have been found which were caused by agents other than the three known types of poliomyelitis virus. The purpose of this study would be to identify and classify these agents and to establish their relationship to non-paralytic polio and other diseases of the nervous system. This research project, for which a federal grant of \$10,275 has been made, will be carried out jointly between Dalhousie University's department of medicine and bacteriology and the Nova Scotia Department of Public Health. It is to be directed by Dr. C. E. Van Rooyen, an outstanding research worker and authority in the virus field who recently joined Dalhousie's faculty of medicine, and Dr. R. C. Dickson of the university's department of medicine.

In New Brunswick a grant of \$2,000 goes towards the purchase of prosthetic appliances and medical aids for use in the province's expanding rehabilitation program.

#### Professional Training

In Prince Edward Island, a grant of \$500 has been awarded to Robert D. Donnelly of the provincial Department of Health for a four-week field training course at the Robert A. Taft Sanitary Engineering Centre, Cincinnati, Ohio. Mr. Donnelly is director of the Sanitary Engineering Division of the provincial health department.

#### Child and Maternal Health

Manitoba will benefit from child and maternal health and hospital construction grants totalling \$33,000. A grant of \$6,700 will be used to help provide for a uniform blood transfusion service in Greater Winnipeg for babies suffering from blood diseases of the newborn. In charge of the service will be Dr. Bruce Chown of Winnipeg, nationally known for his work in this field. The blood transfusion service, which will operate initially on a three-year trial basis, will be based at the following hospitals: Winnipeg General, Grace, Children's, Misericordia, Victoria, St. Boniface and Concordia.

A grant to Ontario for \$93,681 goes towards the purchase of scientific and technical equipment to improve the standards of new-born care in the nurseries and formula rooms of 39 general hospitals in the province. •

#### Used Medical Equipment For a Worthy Cause

In many foreign countries, there is a great shortage of medical and surgical equipment of every kind. It was this need that brought into being the Evangelical Medical Missionaries' Aid Society whose object it is to supply free of charge good, used (and in some instances new) equipment to physicians, surgeons, and dentists in the Mission Field.

As an example of the work of this organization, it has recently served as the clearing house for the Canadian Red Cross Society who donated several thousand blood transfusion sets of a type still very useful but recently replaced in this country by a more modern disposable type. These sets now on their way to such countries as India, Africa, Ecuador, and elsewhere, may well prove lifesavers in many instances and at the same time bring joy to the hearts of those surgeons who use them.

It is suggested that instrument drawers be checked to see if there may be lying about unused, but still usable, instruments and other equipment which may be channelled through this organization to serve a more useful purpose than occupying space here at home.

In addition to such used equipment, interested surgical supply houses have offered the organization from time to time, at bargain prices good, new in-

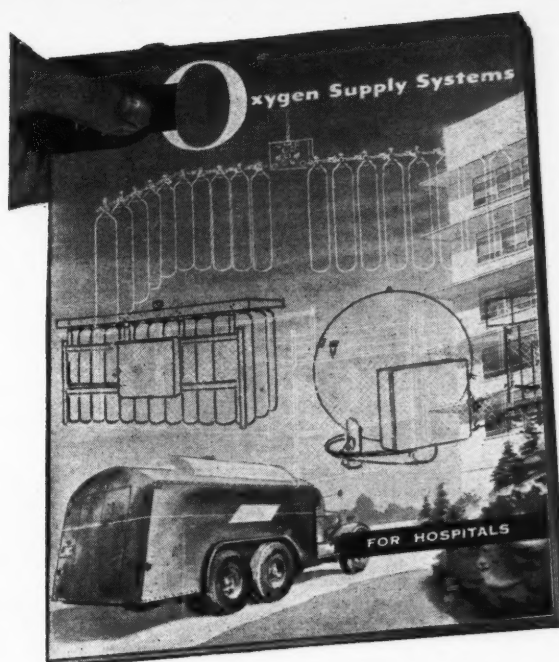
struments, of a type recently replaced in this country by something more modern. In order to take advantage of these offers, donations of cash are most acceptable. Such donations are tax exempt and should be sent to the secretary-treasurer, Dr. R. A. Clappison, 307 Medical Arts Building, 170 St. George St., Toronto, Ont. Instruments, on the other hand, should be sent to the organization at 989 Bay St., Toronto.

#### Use of Opium in India

The quasi-medical consumption of opium in India has steadily fallen — from about 180 tons in 1948-49 to approximately 90 tons in 1953-54 — under a ten-year plan for its abolition adopted by the Indian government.

The amount used today for purely medical purposes in the indigenous system of medicine in India is very small but it is still dispensed by itinerant quacks and shopkeepers who advocate its use indiscriminately in a large variety of common ailments. In the areas where its use is still comparatively widespread, stricter enforcement of legislation, extensive educational propaganda, and the provision of extended medical facilities, are being undertaken. — U.N. News Release. •

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### First Canadian Clinic for Sex Deviates

Canada's first clinic for sex deviates was opened last month in Toronto by the Ontario Department of Health. Under the direction of Dr. Peter Thomson, it is planned as the first of a series to be established in university cities across the province. The second one will probably be in London where it would operate in co-operation with the University of Western Ontario.

The "Forensic Clinic" is contained in 14 rooms of a former nurses' training school on Queen's Park Crescent. It is planned to make this the most modern examination and treatment centre for sex offenders. It is expected the staff will expand rapidly as the courts, and the public become more familiar with the services available.

Establishment of the clinic results from recommendations of a committee which included representatives of the Parents' Action League, Attorney-General A. Kelso Roberts, Reform Institutions Minister John W. Foote, Parkdale MPP William J. Stewart and Dr. Mackinnon Phillips, Minister of Health.

In its initial stage, the clinic will limit itself to diagnosis and treatment of sex offenders sent to it by the courts before sentencing. Later on, with expansion of staff and facilities, the clinic plans to handle sex deviation cases submitted by probation officers, by the John Howard Society which takes care of men discharged from penitentiaries, and by the Elizabeth Fry Society which provides a similar service for women. Eventually, the clinic should be able to accept cases directed to it by private doctors.

An important corollary phase of the clinic's operation will be the instruction of university students in medicine, psychology, or social work.

### Danny Kaye Aids UNICEF

As "ambassador-at-large" for the United Nations International Children's Emergency Fund, Danny Kaye has undertaken his third mission abroad to visit UNICEF aided programs and present his film "Assignment Children" to countries of Europe and the eastern Mediterranean region. The countries include England, Egypt, France, Israel, Italy, Spain, Switzerland, Turkey, and Yugoslavia.

Travelling at his own expense, Mr. Kaye hopes by means of his missions to call attention to the needs of children throughout the world and to the work of UNICEF. His film has been translated into more than 20 languages.

A diplomat is one who can put his foot down without stepping on somebody's toes.

## Coming Conventions

- June 16—British Columbia Hospitals' Association, University of British Columbia, Vancouver, B.C.
- June 16-20—Canadian Orthopaedic Association, Edmonton, Alberta, and Jasper Park Lodge, Jasper.
- June 17-20—Canadian Foundation for Poliomyelitis, Vancouver, B.C.
- June 17-21—First North American Conference for Medical Laboratory Technologists, Chateau Frontenac, Quebec, P.Q.
- June 17-23—Second Congress of the World Confederation for Physical Therapy, Hotel Statler, New York City.
- June 18-20—Canadian Anaesthetists' Society, Mont Tremblant, P.Q.
- June 25-27—Annual Meeting of the Comite des Hopitaux du Quebec, Salle du Manège Militaire, Quebec, P.Q.
- June 25-29—Biennial Meeting of the Canadian Nurses' Association, University of Manitoba, Winnipeg, Man.
- June 26-28—Canadian Dietetic Association, Macdonald Hotel, Edmonton, Alta.
- Aug. 12—Canadian Society of Hospital Pharmacists, Ottawa, Ont.
- Aug. 29-Sept. 1—Canadian Society of Radiological Technicians, Empress Hotel, Victoria, B.C.
- Sept. 12-13—Catholic Hospital Conference of Alberta.
- Sept. 15-19—American College of Hospital Administrators Annual Meeting, Palmer House, Chicago.
- Sept. 17-20—American Hospital Association Convention, Chicago, Ill.
- Sept. 17-20—American Association of Hospital Consultants, Palmer House, Chicago, Ill.
- Oct. 1-5—International Congress on Medical Records, Shoreham Hotel, Washington, D.C.
- Oct. 10-12—Convention, Canadian Association of Medical Record Librarians, Vancouver, B.C.
- Oct. 16-18—Associated Hospitals of Alberta, Macdonald Hotel, Edmonton.
- Oct. 22-23—Catholic Hospital Conference of Saskatchewan, Saskatoon, Sask.
- Oct. 22-24—Ontario Hospital Association Convention, Royal York Hotel, Toronto, Ont.
- Oct. 24-26—Saskatchewan Hospital Association Convention, Bessborough Hotel, Saskatoon, Sask.
- Oct. 25-26—Ontario Conference of the Catholic Hospital Association, St. Joseph's Hospital, Toronto, Ont.
- Oct. 27-29—Canadian Association of Occupational Therapy, Montreal, P.Q.
- Oct. 30-Nov. 1—Manitoba Hospital and Nursing Conference, Winnipeg, Man.
- Nov. 1-2—A. H. A. Institute on Operating Problems of Small Hospitals, Winnipeg, Man.

### Award in Medical Social Work

The National Council of Hospital Auxiliaries of Canada has undertaken, as a project, the provision of an award to a student who wishes to study medical social work. A scholarship fund has been established and it is hoped that, with adequate support, the award can be made an annual one.

### Dependent

Chatting with a hill-farmer at a Cumbrian show, a bishop said: "Yours is a grand life. The best of all, in fact."

"Nay," the old man answered, "farmers hes worst job o' t'lot. They're that dependent on the Almighty." — Countryman.



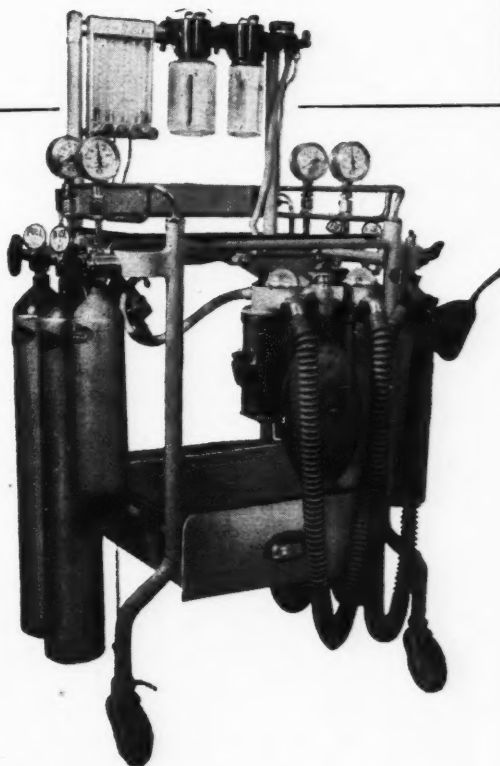
(MEDICAL DIVISION)

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## Central Tray Service

# Faster Please!

THE VALUE of centralization of services in the modern hospital is today undebatable; it has proved itself. Remembering that the objectives of the hospital are promoted through the functioning of its various services, centralization results in greater patient satisfaction, at the same time as it proves economical from the viewpoint of personnel and material. The dietary department, of which the tray service is a part, is of prime importance in our effort to attain this enviable goal. An intermediary between the patient and "production", this service bears the responsibility of promoting or nullifying the work of the latter. Hence the conclusion that one must not under-estimate nor neglect the importance of a service which contributes to a great extent to the good or the bad reputation of the hospital.

These facts were seriously considered by the authorities of Hôpital Maisonneuve. Situation, equipment, organization and functioning of the service were the object of intensive study, numerous consultations, research, study trips, et cetera. It is the result of these studies and the experiences of fifteen months in operation, which we present here to our readers.

Prior to determining the origin and development of this service, it must

**Sr. Rachel Tourigny,**  
Administrator,  
Hôpital Maisonneuve,  
Montreal, P.Q.

be noted that Hôpital Maisonneuve has centralized both the regular and the therapeutic diets; both pass on the same conveyor belt. At first the project seemed a bold endeavour; but reality has proved that it is possible with close co-operation between the area of production, the personnel on the wards, and even the printing office. Co-operation is imperative — being indispensable to the efficiency of the tray service. These joint efforts contribute to a rapid and exact service — a source of pride for the hospital personnel and one of satisfaction to the patient, the *raison d'être* of our institution.

### Situation

A brief description of the general plan of Hôpital Maisonneuve will permit us to locate the area of this service with regard to the rest of the building. The plan is a simple one: at the converging point of five wings is a central circuit containing two elevators on each side. The wings are thus: two converging at either end of the circuit, and the other, between wings

B and C to the rear, referred to as Wing 3; it contains only five storeys while the others have twelve. It is the ground floor of this Wing 3 that houses the dietary department: a main kitchen with its various sections and, between this and the elevators, the tray service area. On either side is a cafeteria, each with its own corridor; beside the one to the right, we find a canteen for the convenience of the public. Thus, the dietary department is a complete unit, truly designed for efficiency, and with access to elevators by two doors opening on to the main corridor. At meal time, one of the elevators is exclusively reserved for the transportation of tray carts. There are other noteworthy advantages, namely, proximity to the purchasing office and to the reception depot, and remoteness from patient wards, with consequent reduction of unnecessary disturbance to the sick.

### The Service Area

A survey of the arrangement of equipment and means of communication will further demonstrate all measures taken to facilitate and accelerate tasks particular to this service.

From the main kitchen let us enter the tray service area through one of the two doors communicating with it; we are now at the place where activity begins at the stroke of the hour for tray preparation. To the left, along the wall is a double cupboard, in the upper part of which is stored the dinnerware, while the lower constitutes a stainless-steel refrigerator for holding individual portions and cold liquids, the upper surface serving as a work-counter.

On the opposite side is a warmer for the various dishes, with three urns atop for coffee and hot water. The dishes for the main course are stacked in automatic heated lowerators located at right angles to these cupboards. Just beyond these is the supervisor's office from which she has a complete view of the service area.

Central to these, and running in the same direction, is the conveyor belt unit, composed of a counter on either side with the belt at the centre. On one side is a warmer for hot foods; on the other are open shelf spaces. The rotating belt assures the smooth and continuous flow of trays. Above the belt, and running the entire length of the unit, is another service shelf.

Along the wall to the left is the bread cupboard with a toaster shelf. Immediately beside it is the dumb-waiter communicating with all patient wards, which is used for special re-



Aerial view of l'Hôpital Maisonneuve, with nurses' residence at the right.

(Continued on page 76)

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(Continued from page 74)

quests or serving meals at irregular hours. Close to this is another shelf area in which are stored the dry cereals and biscuits. It also contains a sink for the upkeep of salt and pepper shakers and for serving fruit juices. Close to this small multi-service area is an intercommunication system permitting instant verbal communication with the various patient units. The space left between this and the main corridor is occupied on one side by a drier and, on the other, by the closed tray carts in alignment. The final area occupying the right angle as one leaves the main kitchen provides for the dishwashing: work shelves, rinse sinks, garbage disposal units, baskets, and automatic washer. The various operations of clearing and dishwashing are performed smoothly without any need to carry dishes from one area to the other. The dinnerware comes from the washer clear and dry and may be piled onto the carts for transport back to the shelves.

The description of the tray service area would not be complete without mention of the ventilating system, the skylights, and the blackboard which also contribute materially to the efficiency of the service.

This, then, is the modern equipment provided; there remains its efficient use in the preparation of food trays.

#### Functioning

The flow of tasks may be divided into six phases: remote preparation, immediate preparation, the actual serving of trays, returning of trays, serving special requests, and evening lunches.

#### Remote Preparation:

This includes the calculation of all the various diets which are afterwards printed and posted. A job description has been prepared to assure the complete coverage of tasks.

Moreover, there is the master selective menu, prepared by the chef in collaboration with the dietitian in such a way as to avoid overlapping and to provide easy adaptation to the therapeutic diets.

The printing office makes a sufficient number of copies of the menus according to the prescribed diets, using a different colour of paper for each type of diet. The forms bear the space for the patient's name and room number, and are distributed on the day prior to use. The patient checks the desired items. However, certain calculated diets are checked by the dietitian rather than being sent to the patient.

Menus are collected by two central tray service employees who then summarize and total the quantities required, while the dietitian reviews

those under her supervision. These are then written on the blackboard for the information of the personnel.

#### Immediate Preparation:

This phase is composed of seven processes, the most important of which is necessarily the actual food preparation by the staff of the main kitchen. While this is being done, the two helpers mentioned above re-check their totals making necessary adjustments for additional menus, et cetera. Then all the menu sheets, both regular and therapeutic, are placed in order of room numbers and put on the over-shelf of the conveyor belt unit at the originating end. Meanwhile, other members of the team prepare all the required cold items. The supervisor and her entire staff take a few minutes to review together the menu for the day and to stress important points, in an effort to guard against possible errors. The dishes are placed at their proper locations; the hot and cold foods are brought to the counter particular to each.

#### The Actual Serving:

A last review and all is found in readiness. Silence reigns in this area of intensive activity. Each helper, together with those from the therapeutic diet section, takes the post assigned to her, the dietitian being at the supervisory control area. The tray carts are lined up at the far end of the conveyor unit.

The belt is put into motion carrying the series of trays on which from either side, salt and pepper shakers, serviettes, sugar, and food dishes are placed "elegantly" by the helpers. The content of each tray is controlled by the selective or prescribed menu which is designated by the colour of the slip on the tray and is easily readable.

At the end of the course, the supervisor takes the menu, checks it with the tray to verify the accuracy of service, and then passes the tray to the helper charged with loading the tray cart. Care is taken to respect the numerical order and thus to facilitate distribution. Each cart, containing fifteen trays, is identified by the marker on which the floor number and the wing area are shown. Two carts are taken on the elevator at the same time and a signal is immediately given by the supervisor to summon ward personnel. *The trays are distributed promptly, according to strict orders which must be carried out at all costs.* Lack of co-operation in this regard would defeat the painstaking efforts of the dietary department, and would give the patient cause for discontent.

#### Returning of Trays:

The collection of trays is the responsibility of each ward. Salt and

pepper shakers are removed and set on the top of the tray carts which are then taken to the service elevator. Back in the tray service area, the shakers are left at the sink-counter while the trays are cleared, the dishes stacked and brought to the counter near the washer, placed in baskets and sent to the section for washing, whence they emerge clear and dry. They are sorted, stacked and placed on a mobile shelf rack to be returned to their proper storage place. Meanwhile, someone is busy cleaning and re-aligning the carts while another cleans the floor area, thus completing the readjustment in preparation for the following meal.

#### Serving Special Requests:

This includes meals and lunches served outside of regular hours, as in the case of late admissions. Ordinarily such requests must be made on the extra menu forms left on the wards; in urgent cases, however, verbal messages by the intercommunication system are accepted. An employee is designated to attend promptly to these requests and to communicate when they have been carried out. Changes in prescribed diets which are received after 11:00 a.m. or 4:00 p.m. are effected only at the following meal.

#### Evening Lunches:

These are served by two employees from the central tray service. This procedure proves economical for the hospital and satisfying to the patient. They proceed to the wards with carts well supplied with various cold and hot beverages, biscuits, et cetera, but they use dishes from the kitchenette on each ward. Passing from room to room, they serve the patients according to their requests. Lunches for patients on special diets are prepared by the diet-kitchen staff and sent to the wards on the dumb-waiter.

#### Practical Conclusions

We have found that the above procedures result in the following advantages:

1. Speedy service and distribution preserves the flavour of hot foods, while the simultaneous serving of regular and therapeutic diets brings satisfaction to the personnel. Let us also note that it simplifies service.

- The control exercised by the dietitian safeguards the accuracy of detail. Her frequent visits to wards for interviews with patients, or to give advice preceding their discharge, afford continuity of effective diet-therapy.

2. Rapid service makes effective the conscientious efforts of the main kitchen to provide wholesome and savoury food.

3. The work of tray service personnel (Concluded on page 94)

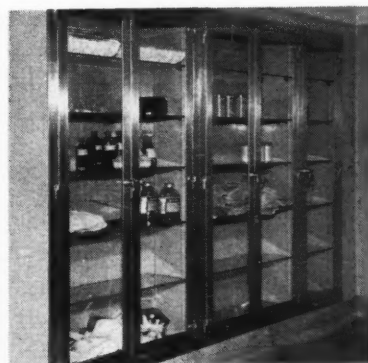
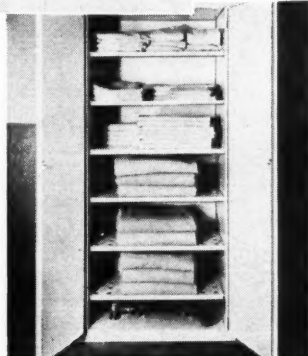
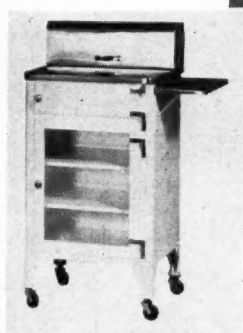
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(Suite de la page 48)

propre et rangé, jusqu'à ce que le va-et-vient du prochain service vienne ajouter à cet aspect, la note caractéristique d'un département ou débordé l'activité.

#### *Service des "spéciaux"*

Il est convenu d'appeler "spéciaux", repas et gouters servis en dehors des heures régulières. Ce qui se produit lors de l'arrivée tardive ou inattendue d'un malade. Il est entendu que l'hospitalière doit alors en effectuer la demande écrite moyennant l'indication des items désirés sur l'un ou l'autre des menus dont réserve est laissée au poste à cette fin. Dans les cas urgents, ou imprévisibles, on s'en tiendra à la demande verbale transmise moyennant le système de communication instantanée. L'employée préposée à ce service des spéciaux remplira la requête et expédiera le plateau par le monte-charge. Ce monte-charge est également employé pour l'expédition et la réception des déjeuners retardés à cause des examens radiologiques ou autres. Ici comme dans les autres services de l'hôpital, il s'avère un indispensable moyen de communication rapide et sûre.

Les changements de diètes, prescrits après 11 heures a.m. ou 4 heures p.m. sont effectués au repas suivant.

#### *Gouters du soir*

Les gouters du soir sont servis par deux employées du service des plateaux. L'expérience prouve qu'il en résulte une plus grande satisfaction pour le malade et une économie matérielle.

Les employées se dirigent vers les étages avec des chariots approvisionnés des divers breuvages froids et chauds, de biscuits, et cetera. Pour le service, elles emploient la vaisselle de la cuisinette de chaque étage. Elles vont d'une chambre à l'autre et servent le malade selon son choix. Il va sans dire que toutes précautions ont été prises quant aux malades soumis à la diète. Préparés par la cuisine des diètes, ces gouters sont expédiés aux divers départements par le monte-charge et portant le nom et le numéro de chambre du destinataire.

#### *Conclusions pratiques*

Le fonctionnement du service des plateaux, tel qu'explicité ci-haut, nous permet d'énumérer les résultats et les avantages suivants:

#### *En regard du malade et du personnel hospitalier*

La rapidité du service et de la distribution des plateaux assure la pleine saveur des aliments chauds, tandis que le service simultané des diètes régulières et des diètes spéciales satisfait et le malade et le personnel hospitalier. Ajoutons sans crainte qu'il simpli-

fie également la besogne du personnel du service.

Quant au contrôle exercé par la diététiste, il s'avère une sécurité pour tous les malades et pour le personnel des départements. Les fréquentes visites des diététistes aux malades, l'explication, au moment du départ de l'hôpital, du régime alimentaire à suivre, sont autant de moyens d'assurer l'effet de la diétothérapie.

#### *En regard du département de production*

Seul un service rapide gardera aux mets chauds leur saveur, ainsi qu'on l'assurait à l'instant, d'où il faut conclure que, de par son bon fonctionnement, le service des plateaux contribue à faire apprécier le beau travail accompli à la cuisine centrale.

#### *En regard du personnel du service*

Le travail du personnel est simplifié par la perfection de l'équipement, par la définition exacte des fonctions des auxiliaires et par les notions de valeurs alimentaires qu'on leur enseigne.

Il importe de souligner que pour compenser à la répartition ingrate des heures de travail, le taux des salaires de ce service a été haussé.

Enfin on a adopté un système de rotation du personnel afin de préparer des substituts pour la "relève" ainsi que pour parer aux absences imprévues.

#### *En regard de l'Administration*

Lorsqu'un administrateur d'hôpital a lieu de constater que le département de nutrition assure la satisfaction du malade et des personnels hospitalier et employé de ces services, il a lieu d'être à son tour pleinement satisfait. L'hôpital existe pour le malade, et le malade s'estime bien servi; l'hôpital fonctionne grâce au travail de son personnel et celui-là se dit content de son sort, voilà qui allège notablement le fardeau de l'Administration, n'est-ce pas? Et si l'administrateur constate en outre, comme il y a lieu de le faire ici, que le système adopté assure une réduction de personnel par suite de la participation de la cuisine des diètes au service des plateaux; un meilleur contrôle alimentaire par la totalisation plus exacte des quantités et la réduction notable des restes par la centralisation du département de nutrition, en un mot, une économie appréciable, n'y a-t-il pas lieu pour cet Administrateur d'exhaler un profond soupir de soulagement et de promener un regard circulaire autour de lui . . . en quête d'autres problèmes à résoudre, d'autres situations à améliorer? *Statistiques . . . et coup d'oeil spirituel*

Il n'est évidemment pas question de course au record du service des pla-

teaux; l'expérience prouve toutefois qu'il est possible d'y servir huit plateaux à la minute, c'est à dire quatre cent quatre-vingts à l'heure ce qui, en soi, constituerait un véritable record. A l'Hôpital Maisonneuve, on a réussi à servir trois cent cinquante-six plateaux en soixante-cinq minutes. On parviendra sans doute à faire mieux, mais ce n'est déjà pas si mal, avouons-le.

Avouons également, pour terminer, que le travail en lui-même n'est pas facile et qu'il demande des sacrifices de chaque employé.

Heureusement que reste comme suprême soutien: l'évasion par en-haut. Ce qui par-dessus tout doit encourager les responsables de ces départements c'est l'éternelle promesse du Maître: "Celui qui donne un verre d'eau en mon Nom, ne perdra pas sa récompense."

Le personnel des départements de production et de service des plateaux n'a même pas la consolation de tendre directement au malade, les aliments qu'il a préparés, servis pour lui. Il ne semble pas présomptueux alors d'assurer que le Maître les récompensera doublement en raison du sourire qu'on n'aura pas vu briller et du merci qu'on n'aura pas entendu.

#### *Clinic for the Isle of Man*

A chest clinic is nearing completion at Noble's Hospital on the Isle of Man. This will enable many patients to be treated on the island instead of, as hitherto, going to the mainland. The clinic will provide a major radiography room and adequate accommodation for radiography services, a lead-lined control room for the protection of operators, and space for storing electro-medical records. The cost was first estimated at £8,250 but rising prices brought an eventual cost of approximately £12,866.

#### *Glaucoma in Iceland*

A systematic search for cases of glaucoma in early stages is being carried on in Iceland where three out of every 1,000 of the population are blind; and glaucoma is by far the greatest cause of blindness.

#### *Design of Hospitals*

(Concluded from page 64)

conditions, one must remember that British and Canadian climate, economics, and customs are sometimes quite different. Nevertheless, this original study can be of great assistance to hospital architects, consultants, administrators, and all those concerned with the subject of hospital design and administration.



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## Regionalization (Continued from page 42)

the form of organization needed to administer the services.

The report on the type of service commenced by outlining the principle involved, namely, that a group of hospitals acting in concert can offer services which one hospital operating on its own cannot afford. In this way, to some extent, the proficiency and standard of medical care, normally found only in large cities, can be achieved in a rural area.

### X-Ray and Laboratory Work

The report pointed out deficiencies in the field of x-ray and laboratory work and emphasized the importance of high standards. The appointment of a supervising x-ray technician and supervising laboratory technician, who would spend perhaps two weeks at a time at each hospital, was suggested. The importance of a regional laboratory with a full-time pathologist was mentioned.

### Physiotherapy

Reference was made to the need for expanding the physiotherapy service at the regional and district hospitals. It was proposed, also, to bring into a general physiotherapy service the clinics then being run by special agencies, e.g. the Canadian Arthritis

and Rheumatism Society and the Crippled Children's Society.

### Regional Pharmacy

The advantages that could result from the establishment of a regional pharmacy were outlined. These included the promotion of a standard drug list, advice to secretary-managers or matrons on the purchase of drugs, and the manufacture of certain preparations.

### Regional Accounting

The report mentioned the help that a regional accountant could give to boards in matters of hospital finance in providing comparative cost statements and in assisting secretary-managers with accounts, the preparation of budgets, and in setting up systems which would afford them sound budgetary control.

Dietetics, medico-social work, medical records, staff training, personnel policies, and bulk purchasing were other subjects contained in the report which were all fully discussed.

The second report set out details of the existing organizations, the South-west Saskatchewan Hospital Association and the Regional Health Board, and indicated various alternative organizational forms which could be adopted to carry out the regional hospital activities. Basically, these were reduced to the choice between a hos-

pital committee, responsible to the regional health board or an independent regional hospital council, achieving liaison with the Regional Health Board by a joint committee.

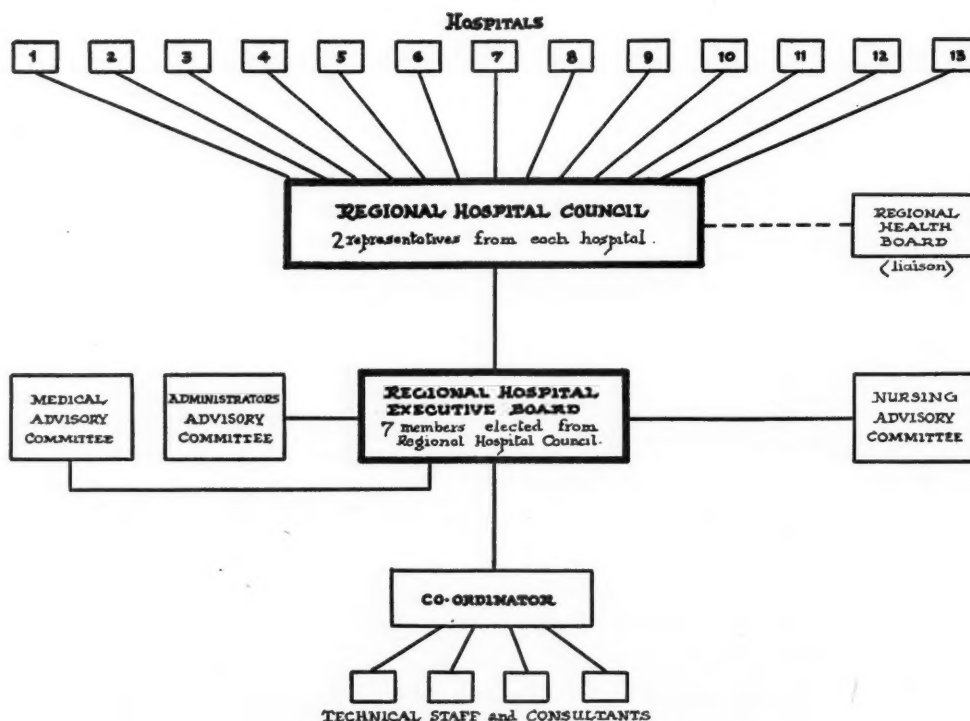
This need for hospitals to achieve a close working relationship with the public health authorities is so important that it really requires a talk devoted solely to the problem. It is unfortunate that many administrators are not prepared to recognize their responsibilities in this direction.

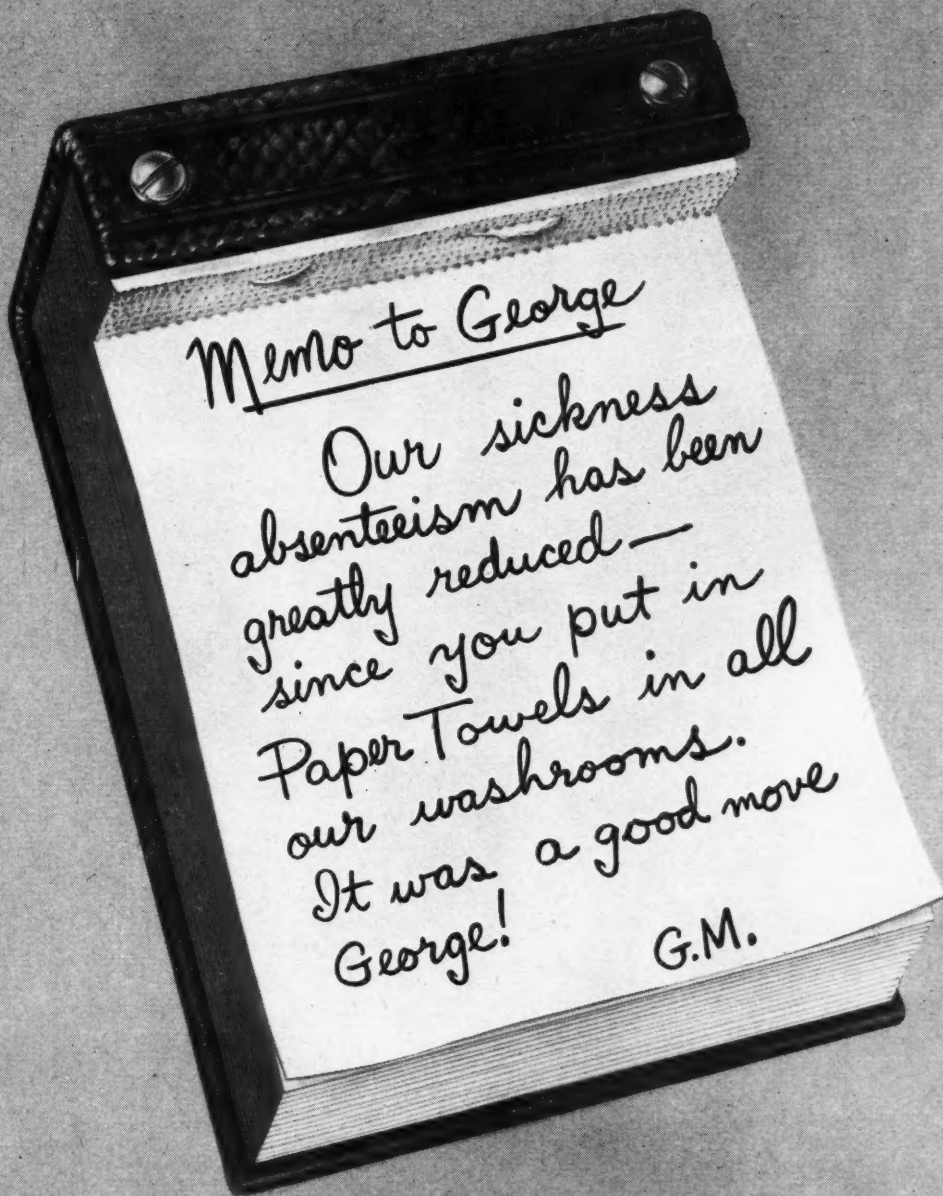
The meeting decided on a regional hospital council, and the matter was then referred to each individual hospital board with the request that they appoint two representatives. It was stipulated that representatives should be board members, as doctors, matrons and secretary-managers would form supporting advisory committees as shown in Fig. 2.

In the meantime, there was a legal obstacle to overcome. It was generally felt advisable that the regional hospital council should be a corporate body since it would have to employ professional and technical staff and also handle funds. The Union Hospital District Act only makes provision at present for boards of union hospitals to be corporate bodies so that a permissive

(Concluded on page 82)

Figure 2  
**Organization Chart**





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## Regionalization

(Concluded from page 80)

amendment to this legislation will probably be the eventual answer. It was, however, necessary to make some provision to cover the intervening period until legislation became available. With the aid of the solicitor to the Saskatchewan Department of Public Health, an agency agreement form was drawn up to meet the situation.

The representatives of the hospitals then met and held their first meeting as a Regional Hospital Council.

The appointment of a regional accountant, a regional pharmacist, a regional dietitian and a supervising x-ray technician was approved, and these staff are being recruited. At the same time, the Council considered and approved a budget for these activities and its allocation to the individual hospitals. The Saskatchewan Hospital Services Plan had already indicated that they were prepared to increase each hospital's budget by the amount of their allocation. The agency agreement form was approved but, as it required the acceptance by each participating hospital, it naturally had to be referred to each hospital board. It provided for each hospital to appoint the Regional Hospital Co-ordinator as its part-time agent for the employment of staff and the purchase of supplies.

## NOW A LEGAL ENTITY

A few months have elapsed since this article was prepared and the Regional Hospital Council will shortly have completed its first year of activity. In the meantime, an amendment to the Hospital Standards Act of Saskatchewan has been passed, making provision for the setting up of regional hospital councils as corporate bodies. The one referred to here has been named the South-West Regional Hospital Council. Besides being now a legal entity, the council program has developed very extensively. The hospitals within the region welcome and make considerable use of the services of the council staff.—P. R.

The Council then proceeded to elect a 7-member executive board, requesting them to prepare a scheme for a regional pathology laboratory, and to examine the possibility of the bulk purchase of various items.

The council has laid down in its constitution that it shall take all possible steps to preserve the autonomy of the governing bodies of the participating hospitals. It has further been decided that the decisions of the Council shall not be binding upon the participating hospitals unless they so agree, but should be recommendations which the participating hospitals would be free to accept or reject.

Subject to these principles, the functions of the Regional Hospital Council are to:

1. Plan for adequate hospital facilities throughout the Region.

2. Disseminate recommended procedures in all departments of hospital organization and operation.

3. Develop such joint administrative services as may be considered desirable and practicable.

4. Develop regional consultative services in medicine, administration and ancillary services.

5. Determine and recommend a personnel policy for the hospitals in the Region.

6. Organize and administer educational programs for hospital personnel.

7. Work in close liaison with the regional public health and medical care programs.

8. Carry out such other hospital or health activities within the Region as the hospitals may agree upon from time to time.

This is a report on the commencement of an experiment. Some time must elapse before it is possible to evaluate any of the results. It is hoped that what has been said will at least be thought-provoking, and will result in some discussion as to what is considered the best type of organization for the future of Canada's hospitals.

## Hoxsey Cancer Treatment Worthless

The U.S. Department of Health, Education, and Welfare has issued the following public warning:

"Sufferers from cancer, their families, physicians, and all concerned with the care of cancer patients are hereby advised and warned that the so-called Hoxsey treatment for internal cancer has been found by the United States Court of Appeals for the Fifth Circuit, on the basis of evidence presented by the Food and Drug Administration, to be a worthless treatment."

The Federal Food, Drug, and Cosmetic Act authorized dissemination of information regarding drugs in situations involving imminent danger to health or gross deception of the consumer.

The Hoxsey treatment for internal cancer involves such drugs. Its sale represents a gross deception to the consumer. It is imminently dangerous to rely upon it in neglect of competent and rational treatment. The treatment referred to is given at the Hoxsey Cancer Clinic, Dallas, Texas, or Portage, Pennsylvania.

The Food and Drug Administration has conducted a thorough and long-

continuing investigation of the treatment. Hoxsey's claimed cures have been extensively studied and the Food and Drug Administration has not found a single verified cure of internal cancer effected by the treatment. In addition, the National Cancer Institute of the United States Public Health Service has reviewed case histories submitted by Hoxsey and advised him that the cases provided no scientific evidence that his treatment is of any value. Those afflicted with cancer are warned not to be misled by the false promise that the Hoxsey cancer treatment will cure or alleviate their condition.

## Honest Answer

A son in college was applying pressure for more money from home. He wrote his dad:

"I can't understand why you call yourself a kind father, when you haven't sent me a cheque for three weeks. What kind of kindness do you call that?"

His father replied immediately:

"That's unrelenting kindness." — *Davis Nursing Survey.*

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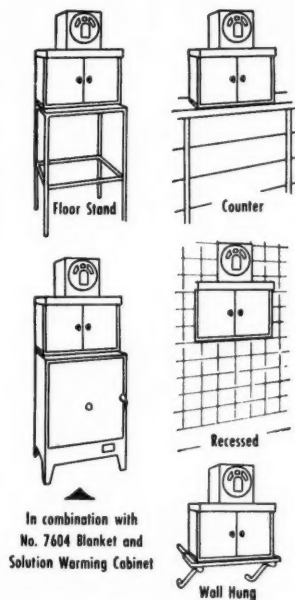
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## London Ambulances in Out-patient Service

TO THE average man in London, England, sleek white ambulances moving determinedly through the city's ancient and congested streets are as commonplace as four o'clock tea or the red-coated guards in front of Buckingham Palace. But visiting public health officials from all over the world have called the London County Council's Ambulance Service the best there is—in any big city.

Why the superlatives? The answer is contained in the Service's more than 40 years of accomplishment — and knowledge that has been gained through two world wars.

In a nutshell, the Service can boast of: 335 ambulances and auxiliary vehicles that can deliver street accident victims to hospitals less than five minutes after arriving at the scene; transporting tens of thousands of out-patients yearly to and from hospitals at a tremendous saving of time and money to patient and hospital; and an elaborate organization of more than 700 personnel who can cope efficiently with large-scale emergencies

if and when they strike the city.

London County has 3,500,000 inhabitants. However, its population zooms to more than 7,500,000 every day. Commuters who work in the city and visitors make up the difference. The county sprawls over a 117-square-mile area on both sides of the historic Thames.

To meet the city's needs, London's ambulances are housed in special stations dotted strategically about the city. There are 40 ambulances assigned to 19 "accident" stations which are manned round the clock by drivers and administrative personnel. In addition, there are 295 ambulances in six "general" stations which are primarily concerned with out-patients.

No point in London is more than two miles from an ambulance station. And each station is a miniature medical dispensary in itself—containing medical supplies required for any one-shot ambulance call. For major disasters, the LCC maintains two "emergency tenders", huge vehicles which are really rolling hospitals, full of

equipment permitting wide-range treatment and simple surgery.

The heart of the Ambulance Service is located in the County Hall (similar to any municipal government building) in the southeast section of the city. Here you can see the dramatic accident division in action.

When, in an emergency, you need an ambulance in London, you simply dial 999 on the nearest telephone. A special operator answers and says "police, fire, ambulance". If you reply "ambulance", you are hooked up immediately with a central control switchboard in County Hall. There, one of a dozen operators takes your call and records all pertinent information.

Thus, the operators can tell in seconds which station can provide the quickest service for any address in the city. For any street accident anywhere in London, the LCC, from experience, knows that it should take an ambulance no longer than 7.1 minutes to reach the scene, 6.7 minutes at the scene, and finally 4.6 minutes to get the victim to the nearest hospital.

Similarly, there are prescribed aver-  
(Concluded on page 86)

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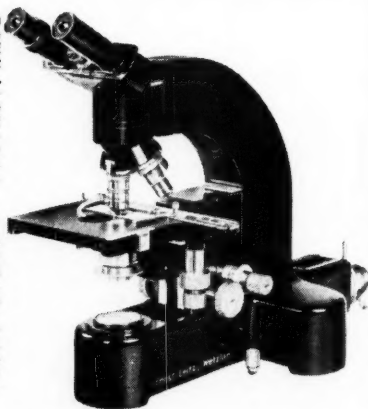
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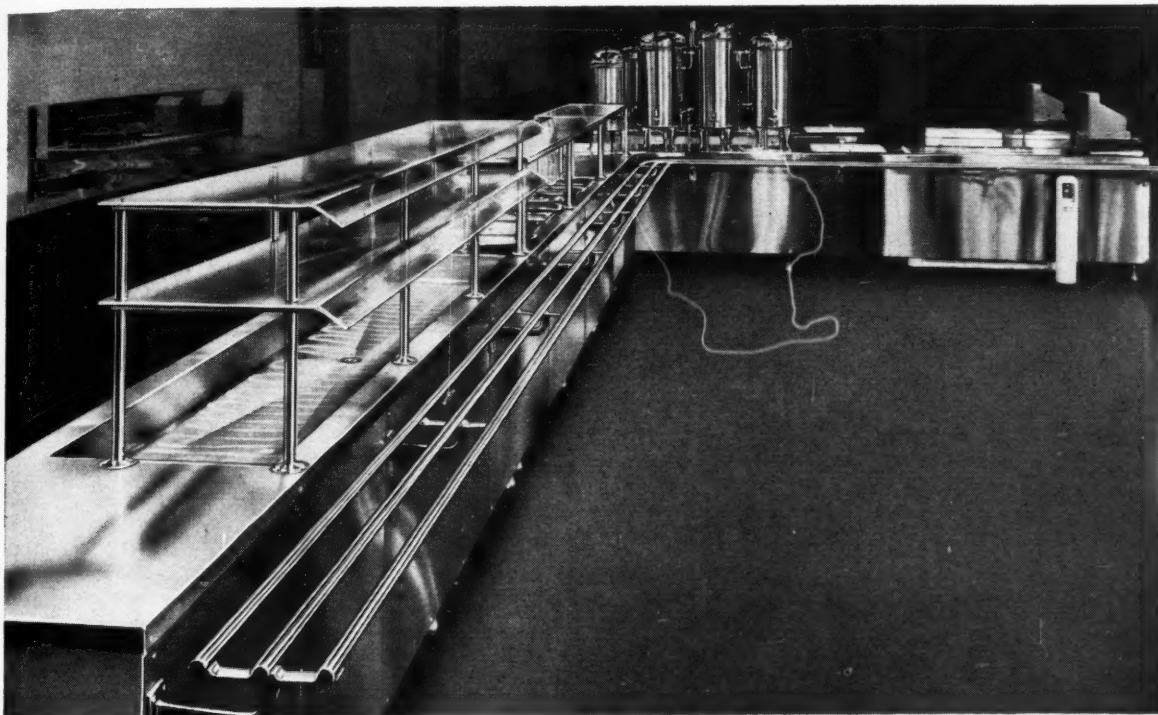


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## London's Ambulances (Concluded from page 84)

age "to, at, and from-the-scene times" for every type of emergency. The over-all average is slightly more than 21 minutes to reach the scene and deliver the patient. All of this, incidentally, takes place without benefit of blaring ambulance sirens or police escorts.

Dramatic as it is, the accident division is only one small part of the LCC Ambulance Service. The out-patient division, which carries out more than 80 per cent of all calls, is cited by

LCC officials as unique. Through this division, upwards of 1,000,000 trips per year are made taking sick people to and from hospitals for out-patient treatment. Many of these are wheel-chair cases. Others are bedridden.

London out-patients can be taken to the hospital for the equivalent of from \$2 to \$5 per week. Hospitalization for a week costs from \$45 to \$56. Thus, the saving for a single patient can run as high as \$50 or more per week.

There is still another benefit derived from the ambulance out-patient program. Using it, hospitals know they

can release in-patients earlier than they would otherwise. This makes for faster patient turn-over and often precludes unnecessarily long hospital stays. Also it enables hospitals to plan out-patient care more effectively.

At times, LCC ambulances are called upon to perform in special circumstances (They comprise a unit of London's civil defense). Three years ago, this city was blanketed by one of the worst fogs in its foggy history. Visibility was zero. But still, emergency cases and out-patients had to be taken to hospitals.

While one attendant remained in the ambulance the other got out and walked in front of the vehicle with a lighted flare in hand. Thus guided, ambulances proceeded on their missions at walking speed. Some men had to walk as much as 15 miles on one trip—always lighting the way.

When a few collapsed from the ordeal the British Broadcasting Corporation issued an appeal for off-duty drivers. Enough crews for 20 additional ambulances responded. That's the sort of stuff the LCC Ambulance Service is made of.—Reprinted from "Scope Weekly", Courtesy The Upjohn Co.

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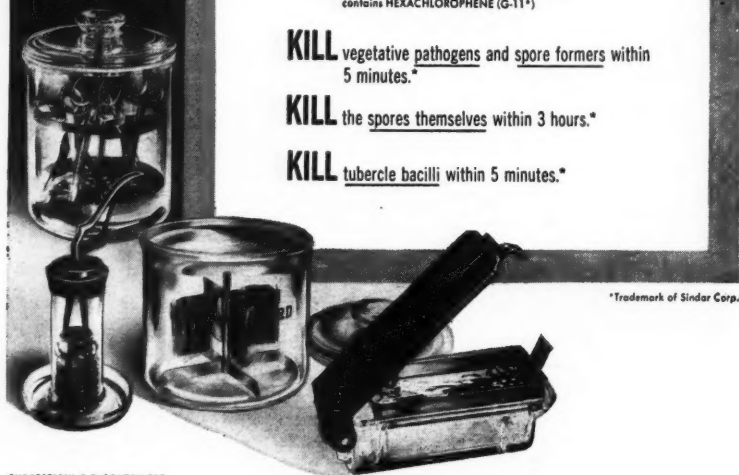
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It seems that children on Quebec's lonely "Côte Nord" — the strip which runs between Sept Îles to the Straits of Belle Isle — don't have to be coaxed to have their x-rays taken. In fact, they are more than willing. Part of this willingness is the result of the excitement which mounts when the *Maris Stella*, Quebec's floating x-ray clinic, docks at the various harbours along the coast. But most of it stems from the fact that every child who has an x-ray taken is entitled to one free movie ticket — and movies are a rare thing in this particular part of the province. A member of the clinic's team looks after the showings, and it's an unusual child who doesn't show up for his x-ray when the *Maris Stella* comes to town.

## Had No Effect

The young interns were discussing theories about pre-natal influence.

"Obviously, there's no such thing," scoffed one. "It's been disproved time and time again. For example, before I was born, my mother broke a huge batch of phonograph records. But it's never bothered me . . . never bothered me . . . never bothered me . . ."—*Davis Nursing Survey.*

A man never knows what he can do until he tries to undo what he has done. — *Frances Rodman.*

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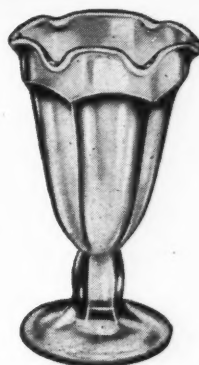
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## Long-term Hospitals

(Continued from page 45)

as over 65. Victoria had 14 per cent; and this is the age group which contains most of the chronically ill.

"Geriatrics" is a word most of us had never heard until a few years ago and now it is as common as "paediatrics". There are, of course, doctors who specialize in this field. As our population increases, the place of chronic hospitals in our communities becomes ever more important.

In order to familiarize you with the steps to be taken if your community is thinking along these lines, I would like to give you a "case history" of the Gorge Road Chronic and Convalescent Hospital in Victoria, which opened its doors during the early part of 1955.

In March of 1944, the Council of Social Agencies in Victoria was advised of the great need for nursing care for patients who were occupying hospital beds and who no longer needed acute hospital care. Finally, after much deliberation, an old private home was purchased by the city and a grant obtained from the provincial government for furnishings. This house was remodelled and, believe it or not, was

used for ten years, housing 41 patients. It was called the Victoria Nursing Home and while it served a useful purpose, it was totally inadequate as a chronic hospital. During these years, the Board of Directors envisioned a new building with the latest equipment and treatment facilities, and continuously worked toward this end.

In 1951 the provincial government made a survey of chronic hospitals and, because it found the need in Victoria so great, gave permission to the Board of Directors to proceed with plans for the Gorge Road Hospital. Advisory help as well as financial aid came from both the federal and provincial governments. The estimated cost of the hospital was \$450,000. The federal and provincial governments each gave one third and the city of Victoria contributed the remainder.

This hospital was deliberately and carefully planned to give a maximum of service, with a minimum of maintenance costs. Among the many special features incorporated in this modern hospital are handrails in all the corridors and bathrooms, ramps for easy access to all parts of the building, and an inter-communication system

between patient and nurse. A large patio was built to enable the patients to enjoy the benefits of fresh air and sunshine. Three large sunrooms were designed to give this hospital a home-like, cheerful atmosphere. The patients were encouraged to use these facilities which play a large part in the treatment program.

## Furnishing Fund

During the inception and construction of the actual building a furnishings committee was active. Although the provincial government paid its share of one third of the cost of furnishings, two thirds remained to be raised by public subscriptions.

Interest was aroused and the community became conscious of the 104-bed hospital when the "furnish a room" plan was explained. Letters were sent out to all organizations whose aims were known to be philanthropic. In most cases, a speaker followed and solicited support in raising funds for furnishing a room or a ward. These organizations had almost a year in which to work before the hospital was to be completed. Each one signed a pledge and worked towards its main goal.

(Concluded on page 90)

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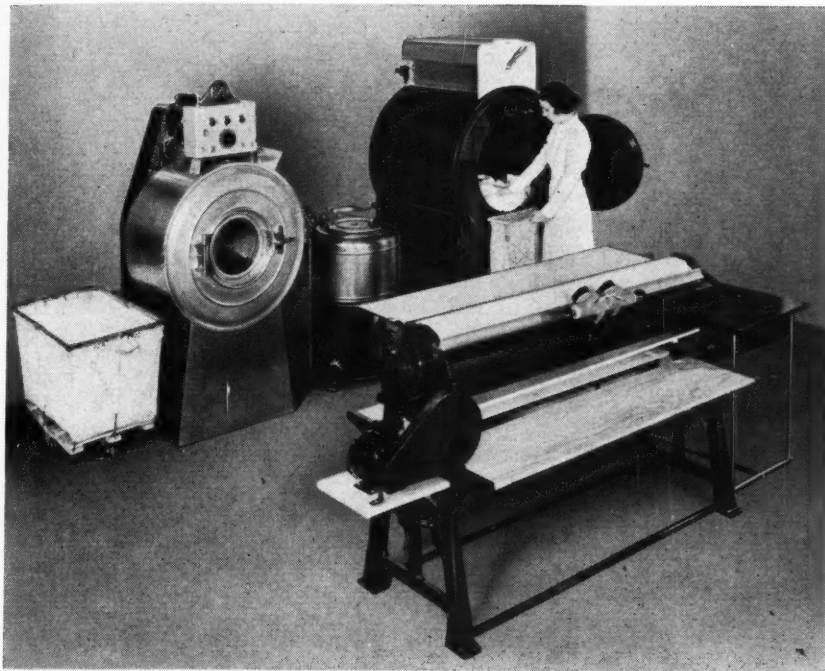
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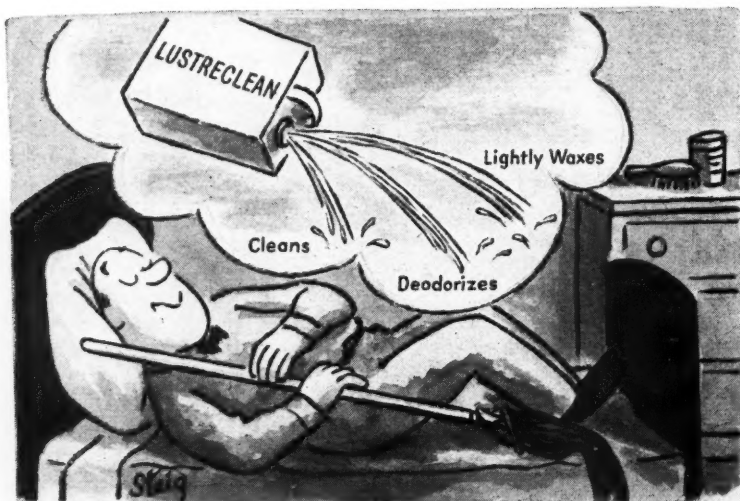
## More Children die of Accidents than Disease

Accidents have become a serious and often a leading cause of death among children and adolescents, whereas mortality from communicable diseases — formerly very high — is continually decreasing. These facts are shown in a statistical report\* published by the World Health Organization, which presents statistics from 18 countries on deaths caused by accidents other than transport accidents.

In certain countries, accidents accounted for nearly one-half of all deaths occurring among boys between 5 and 9 in 1953. Up to 96.4 per cent of infants who die accidentally in their first year of life are victims of suffocation (44.3 per cent in their cradles and 52.1 per cent from choking on food or other objects). According to the WHO report, the most dangerous accidents apart from road acci-

dents are: falls, which in some countries are responsible for up to two-thirds of all accidental deaths; drowning, which may account for up to one-third; fire and explosions, which sometimes cause up to one-quarter; and poisoning, accounting in some places for nearly one-fifth of all accident victims. Children between 1 and 4 years of age are the main victims of poisoning and burns; the age-group 15 to 40 is most liable to machine accidents; and the 15 to 25 age group, to firearms accidents. Those involving fire affect mostly children between 1 and 10.

\*WHO Epidemiological and Vital Statistics Report, Vol. 9, No. 1, 1956.



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## Long-term Hospital (Concluded from page 88)

Public relations committees kept everyone keenly interested. The press co-operated and publicized each week one or more functions whose proceeds were going to the furnishings fund of the Gorge Road Hospital. The hospital auxiliary, a group of but 23 women, shouldered its responsibility and contributed \$10,000. Individual donors and business houses gave generously and finally \$50,000 was raised.

Quality, durability, and cheerful colours were the main consideration in choosing furnishings. Draw drapes were used in all rooms, giving a pleasing atmosphere. Special bedside tables were constructed to suit the needs of the chronic patient. The upholstery for all the chairs and chesterfields was nylon frieze, chosen for washability. Loyalist maple furniture in shades of wheat, gave the dining room a home-like touch. The kitchen, too, was built with foresight for it is capable of catering for 300 patients, should additional wings ever be added. A treatment room was established and a small pharmacy outfitted. This hospital was, in fact, designed to be adequate, in every detail, to help chronic sufferers renew their hopes of recovery.

This has been a very brief history of the Gorge Road Hospital; but it will give you an insight into the planning necessary should your community undertake such a project. Building a chronic hospital has its own reward—that of seeing the chronic patient become no longer a problem and a burden, but through proper care and treatment, a useful member of society again.

There is this difference between happiness and wisdom: he that thinks himself the happiest man, really is so; but he that thinks himself the wisest, is generally the greatest fool.

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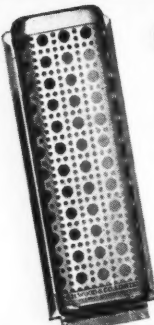
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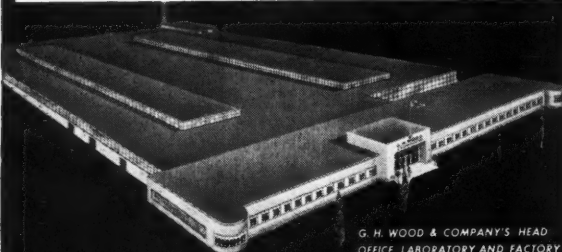
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## Commission Collective de l'Accréditation Abandonne le Système d'Evaluation par Points

**L**A COMMISSION collective de l'accréditation des hôpitaux, tout comme n'importe quelle autre organisation stable, a marché de pair avec les temps modernes. Elle a récemment examiné en détail ses outils et, par conséquent, ses inspecteurs utilisent aujourd'hui une formule de rapport révisée. On y a fait nombreux changements qui intéresseront tous les hôpitaux. Comme résultat d'une de ces révisions le système d'évaluation par points n'est plus employé. Au lieu d'une évaluation basée en grande partie sur le nombre de points reçus, le jugement de l'inspecteur et la revue subséquente par la commission collective décideront à l'avenir si l'hôpital sera accordé une approbation provisoire ou complète.

On a classifié comme essentiel la pharmacie et le contrôle de drogues, qui formaient auparavant une division complémentaire; c'est à dire, en plus des huit départements ordinaires de cette catégorie, un hôpital doit contenir une pharmacie ou un dépôt contrôlé pour drogues, comprenant un système satisfaisant pour le contrôle des drogues, avant qu'il puisse être considéré pour l'accréditation. Cela ne veut pas dire qu'il faut employer un pharmacien gradué.

Trois nouvelles divisions ont été ajoutées au groupe complémentaire et de service général. Ils sont: (1) la dentisterie, où on souligne l'importance d'intégrer le département avec l'organisation et les services du personnel médicale; (2) cas d'urgence, où on considère comme très important le degré auquel les facilités peuvent répondre aux besoins de la région dont il s'agit; et (3) des services spéciaux, pour inclure certains services compris auparavant ailleurs. Cette dernière division indique que les membres de la commission collective ont fait preuve d'un grand intérêt pour aider les petits hôpitaux à recevoir l'accréditation. Des services tels un personnel interne et une école d'infirmières recevaient autrefois des points en dedans des divisions essentielles de l'organisation du personnel médicale et du service de nursing respectivement. Ces services n'étaient pas du tout praticables dans beaucoup de petits hôpitaux, et ce fait est reconnu dans le rapport révisé. Ils y sont inclus comme une partie des services spéciaux de la division complémentaire. Une programme pour le contrôle du cancer et un examen régulier des poumons par rayons-x sont aussi inclus dans la catégorie des services spéciaux. De la même manière, les départements de pathologie et des rayons-x étudient la compétence des facilités et du personnel du certain hôpital, plutôt que les travaux qui ne pourraient être accomplis que dans un département spacieux possédant des instruments coûteux et un personnel spécialisé.

Il y a beaucoup de changements mineurs dans la formule de rapport de l'inspecteur; la plupart des questions positives qui ne demandent pas le jugement personnel de l'inspecteur ont été incluses dans un questionnaire plus élaboré qu'on envoie à l'hôpital avant la visite de l'inspecteur. Par conséquent, on donne beaucoup plus d'importance à l'évaluation de l'inspecteur qu'on ne donne à des détails particuliers concernant la compétence d'un département. Il y a cependant quelques divisions, telles celle qui concerne le bâtiment lui-même, qui sont devenues plus détaillées avec l'addition de questions aux sujets de protection contre le feu, rapports du pompier en chef, et l'éclairage en cas d'urgence. Toutes les réponses au questionnaire et au rapport d'inspection sont importantes. Il semble qu'on veuille souligner de plus en plus la qualité des services, et maintenir comme but constant, le soin adéquat du malade et sa sureté.



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## Faster Please

(Concluded from page 76)

nel is simplified in direct proportion to the quality of equipment, to the clarity of job definitions, and to their knowledge of food values. Salary adjustments have been made to compensate for the irregular work hours.

Then, too, a rotation system familiarizes the personnel with one another's various duties and thus makes provision for the inevitable replacements which may arise, without disruption of service.

4. When a hospital administrator can be confident that the dietary service functions to the satisfaction of the patient and to the nursing and service personnel as well, she can be justly proud of that fact. The hospital functions through the co-operative efforts of its personnel — and they, in turn, experience job satisfaction. These factors are of a nature to lighten noticeably the burden of administration. Furthermore, our experience proves that this close centralization and co-ordination of dietary services (a) reduces the number of personnel required for this department; and (b) allows for

more accurate measuring of required quantities of food, thus reducing wastage. Truly, in such a situation, the administrator can, with a sigh of relief, turn to the many other problems which require her attention and solution.

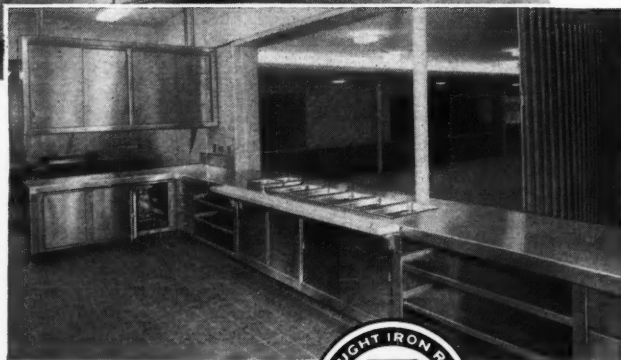
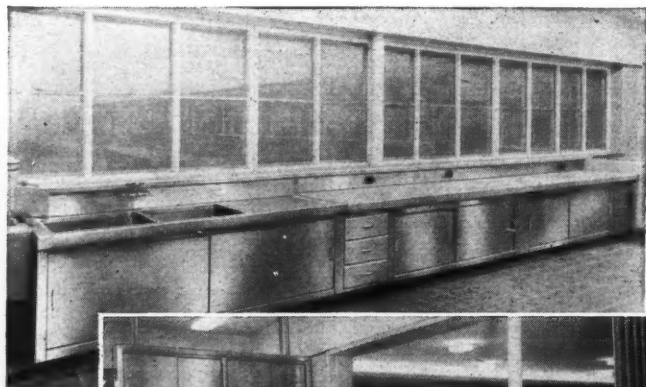
5. It is not usual to try to establish speed records in the serving of trays. However, our experience demonstrates that we can serve at the rate of eight trays per minute, or 480 per hour, which almost does constitute a record. At present, we serve an average of 356 trays in 65 minutes. We may improve on this but, for the moment, we do feel that our present efforts are gratifying.

Let us frankly admit that the task of operating this department is not an easy one and the work of each employee is very demanding. Fortunately there is the "spiritual outlook". Does not the Divine Master's promise, "He who gives a glass of water in My name shall not be without his reward", find a fitting application here? The personnel of these services cannot even have the pleasure of bringing to the patient the nourishment which they have prepared and served for him. It does not seem presumptuous, therefore, to be confident that the

Master will doubly reward them because of the grateful smile which they do not see and the welcome word which they do not hear.

## "Hospitalized"

While I was exploring the decline of expression in America, I spent a week in hospital. Medical science has done much for humanity but not in the area of verbal communication. It should undergo a prefectomy, and have some of its prefixes taken out. I should like to see the "semi" removed from semi-private, a dispiriting word that originated in hospitals; there must be a less depressing way of describing a room with two or more beds. I am also for taking the "sub" out of "sub-clinical" and starting all over again with the idea in mind of making the word mean something. Incidentally, I discovered at the hospital the difference between "to be hospitalized" and "to become hospitalized". The first means to be placed in a hospital, and the second has two meanings; to get so that you can't stand it in the hospital any longer, and to like it so much there that you don't want to leave.—James Thurber, in the "New Yorker".



Upper—Vegetable peeling and preparation area.

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*Part of the 110 trucks lined  
up to begin the hospital  
move*

More than 500 volunteers and 110 huge trucks moved 97 patients and 7,000 pieces of equipment from the old to the new St. Mary's Hospital in Evansville, Indiana.

*More than 3,000 volunteers, receiving only local attention in 1950, raised more than \$1,000,000 for the new St. Mary's in a campaign planned and directed by Lawson Associates.*

You learned of "Operation Good Neighbor" through newspapers and national television and radio programs in mid-March. This was news. It was something different, out of the ordinary. (The Hospital funds campaign was not national news; it was a quite ordinary success).

Four hundred truckers of Teamsters Local 215 in Evansville manned vehicles supplied by the Southwestern Motor Carriers Association, member of the Indiana Motor Truck Association. The operators provided 70 supervisory personnel to coordinate this move with police, Civil Defence Observers and National Guardsmen.

Truly, this was "Operation Good Neighbor".

But more credit is due to the thousands who volunteered in the various divisions of the 1950 fund raising campaign which provided much of the hospital's financial needs. These men gave not only of their time, but of their means, in order that they might be assured better hospital facilities. They gave out of their sense of responsibility to St. Mary's Hospital.

How do you get the public to give active support to your hospital in its time of need?

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*A young patient being  
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## The Eradication of Debilitating Diseases

Modern public health programs are directed at breaking the vicious circle between disease and poverty. Prevention of disease is important to economic development because it reduces the losses of productive power caused by illness and provides a more productive and healthy population, capable of earning higher incomes. The World Health Organization has helped governments to achieve remarkable results in the campaign against such diseases as malaria, tuberculosis, yaws, trachoma, leprosy, small pox, cholera, and many others, but illness is still a serious handicap to economic and social development in all under-developed countries.

Ten years ago, the complete eradication of malaria throughout the world would have been a utopian dream; but an intensified campaign since World War II has produced almost unbelievable results. If control measures can interrupt the transmission of malaria for a number of years, the disease will be eradicated and DDT spraying operations may be replaced by a system of checking and surveillance. It has recently become apparent, however, that there may be a time limit

beyond which the new insecticides are no longer effective. The World Health Organization is therefore urging that nation-wide malaria eradication projects be pushed ahead with the utmost speed and vigour. Of some 600,000,000 people exposed to malaria, an estimated 370,000,000 still have no protection and it is obvious that the world-wide eradication of malaria remains a great task, especially in view of the fact that the disease can so easily travel through vector mosquitoes. Very tentative estimates suggest that the total cost of malaria eradication in ten countries of Asia, Europe and Latin America would amount to some \$228,000,000, while a similar tentative estimate for 28 countries and territories in the Middle East, southern Europe, South East Asia, and the Western Pacific reaches a total of over \$470,000,000.

A broad program is urgently needed to include disposal of waste and refuse, the provision of safe drinking water, the control of disease-carrying insects, rats, and other related matters. For this purpose, trained personnel are lacking and their provision would call for the establishment of regional train-

ing centres and for substantial financial aid. An organization would be required to operate on a sufficiently large scale to make a real impression upon the sanitary environment of a country. To meet this problem, field demonstration and training projects have been established in a number of countries. Individual projects for the construction of wells, piped water supplies, latrines, et cetera, could be used to give practical experience to national personnel who could then play their part in an expanding program. — *United Nations Department of Public Information*

### Fellowship for Graduates in Hospital Pharmacy

The Canadian Foundation for the Advancement of Pharmacy has established an annual graduate fellowship to assist a Canadian graduate in pharmacy to pursue further studies in hospital pharmacy. Selection of the recipient is to be made by the foundation's Committee on Pharmaceutical Education and Research, together with a member of the Canadian Society of Hospital Pharmacists. It is hoped that the fellowship will stimulate further interest in hospital pharmacy among students.

## THE PRACTICE OF

# PSYCHIATRY in General Hospitals

By A. E. Bennett, M.D., E. A. Hargrove, M.D., Bernice Engle, and contributing authors. Foreword by Daniel Blain, M.D. Introduction by Karl M. Bowman, M.D.

• The medical, economic, and social advantages of psychiatric units within general hospitals are being recognized, but the method of organizing and operating such units presents many special problems. In this volume experts and pioneers in the field give practical information on staffing and training, administration and finance, referral, insurance coverage, medicolegal problems, special treatments, the operation of day hospitals and many other related matters. For all doctors, psychiatrists, nurses, and hospital trustees, architects, and administrators who are concerned with the medical and social problem of mental illness.

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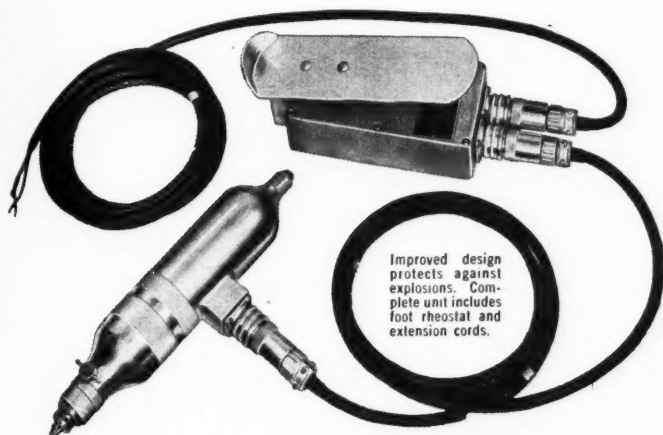
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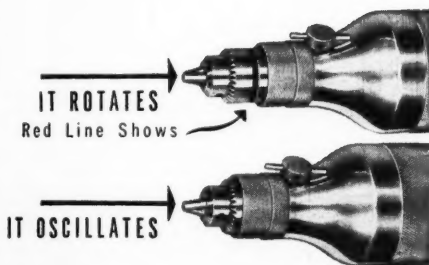


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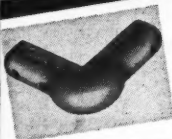
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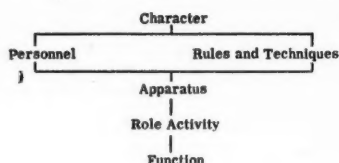
105-30th Street, Toronto 14.

## Social Sciences

(Concluded from page 38)

of society and culture into a more easily identifiable operational unit. The concept of institution is used in both a general and a specific sense. Examples of its generalized usage are the economic, political, religious, educational, correctional, health, or family systems of a nation or tribe. Examples in a more specific sense would be a factory, a court, a church, a school, a prison, a hospital, or a family, and it is this latter use of the concept that concerns us mainly at present.

One may ask whether it is possible to identify and describe certain fundamental, universal, and comparable variables in specific institutions (i.e., factory, church, school, family, hospital, et cetera). The answer is yes, and within the frame of reference of our concepts of structure and pattern, or society and culture. The diagram below is no doubt a familiar one:



One can, through use of these conceptualized variables, analyze, compare, and appraise various types of institutionalized behaviour shared within the membership. The term institutionalized is applicable to paired or multiple relationships between persons of different status within the structured unit. Examples would be relationships between superintendent and worker in a factory; clergy and layman in a church; teacher and student in a school; parent and child in a family; and physician and patient in a hospital. Multiples of these status-personal relationships are easy to imagine, and it is the degree to which they are structured, patterned, repetitive, and predictive that makes them significant to us.

If it were practicable it would be my choice to explore four major sets of these relationships in medicine: the community, the hospital, the family, and the office or clinic. However, in this paper, I shall confine myself to the hospital and the community.

(Continued in next issue)

Switzerland's *Journal de Genève*, commenting on conferences: God needed only six days to create the world, but He had the advantage of working alone.

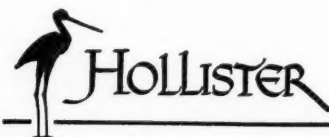
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## Provincial Notes

(Concluded from page 56)

**FREDERICTON.** A \$600,000 extension to the Victoria Public Hospital will assist in construction of a 100-bed wing for the hospital. Construction is expected to start in September and to be completed by December 1957. This hospital also has a new electro eye magnet, used to take particles of metal from eyes, which cost approximately \$1,700. It is used for only four or five seconds at a time. Much more powerful than the old type magnet, the large electro eye magnet does not need to be as near to the eyes to be effective.

**MONCTON.** The official opening of the new \$1,000,000 wing to Hôtel Dieu de l'Assomption took place recently. The new brick wing is of fire proof construction, and adds 85 beds and 35 bassinets to the capacity of the hospital. This makes a total bed capacity of 228.

## Nova Scotia

**AMHERST.** Because of a decline in the number of tuberculosis patients in

the province, the 17-bed Tbc. annex at Highland View Hospital will be closed out and converted for maternity purposes. Plans for the alterations to the hospital have been drafted.

**HALIFAX.** A cobalt deep therapy unit is to be installed at the Victoria General Hospital, the province's main cancer treatment centre. Thick concrete walls must be erected to house the unit and other facilities must be provided for reception, examination, and necessary care of patients. The cobalt unit will make possible more powerful treatment of deep-seated tumors in a shorter time than is possible with x-ray therapy equipment.

## Discovery in Tuberculosis

To a woman bacteriologist at the Royal Edward Laurentian Hospital in Montreal, P.Q., goes most of the credit for discovering a new and faster method of detecting the presence of active tuberculosis in possible victims of the disease. Dr. Edith Mankiewicz and her staff at the hospital have found that it is possible to detect tubercle bacilli in two weeks, whereas it formerly took five. The improved

method consists of tracing the bacilli with a yeast which will grow only on a laboratory culture containing other tubercle bacilli. The discovery means that spread of the disease is checked by early isolation of the victim and much of the patient's anxiety is alleviated by the shorter waiting period.

## Value of Statistics

We do not value statistics for their own sake but only as they pay for their keep by enabling us to make better plans, to check performance, to close budget gaps. Through statistics we enlarge our individual experience, obtain facts in definite form, simplify and classify numerical facts so as to make them readily comparable and qualify ourselves to interpret conditions and foresee trends and tendencies. Without planning we cannot control either business or domestic finance and planning can only be done effectively when we have a knowledge of conditions such as we gain from perusal of statistical information.

It is a man's own fault, it is from want of use, if his mind grows torpid in old age. — Samuel Johnson.

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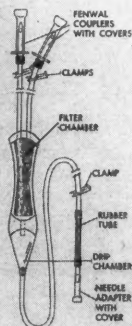


These disposable, two chamber recipient sets reduce costs three ways—through fewer changes during single infusions of whole blood—through repeated use during multiple infusions—through the elimination of pre-filtering.

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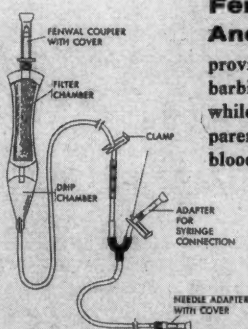
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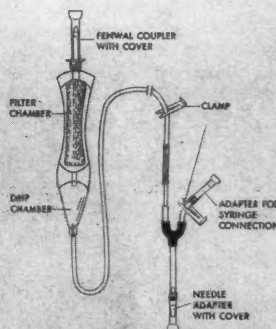
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## Twenty Years Ago

("The Canadian Hospital", June, 1936)

Studies of cyclopropane anaesthesia have now been conducted for several years by numerous competent investigators; and increasing clinical experience indicates that cyclopropane is a valuable anaesthetic agent.

The training and experience which nurses get in a psychopathic ward will assist and add to their efficiency in other divisions. They will recognize and meet situations arising from time to time, without upsetting the patients and their friends, when they have some confidence in their own ability to cope with such conditions. With the increasing interest in this branch of medicine, no large hospital can afford to be without such a department for the training of the staff and to meet the demand of the public.

The first annual meeting of the Canadian Dietetic Association held in Toronto, May 22nd and 23rd, got under way to a grand start with 250 dietitians registered, from points as far west as Alberta, and as far east as New Brunswick. . . .

. . . On Friday evening, May 22nd, during the same convention, the hospital dietitians met at an informal dinner for discussion of mutual problems. There were in attendance over 50 dietitians, with Kathleen C. Burns of the Hospital for Sick Children, as Chairman. Seated at the head table were Winnifred Moyle of the Toronto General Hospital, Mary Chute, R.N., of the University of Toronto School of Nursing, Dr. Gladys Boyd of the Hospital for Sick Children, and Ruth Park of Montreal General Hospital.

The preservation by freezing of small fruits and some vegetables has developed into an important industry in the United States. In Canada, however, the development of the industry has been much slower, and in most instances the pack is limited to strawberries for ice-cream flavouring, sour cherries for bakery use, and green peas for use in hotels and similar institutions.

The little town of Antigonish in Nova Scotia is always doing something to make Canada sit up and take notice . . . Arrangements have now been effected whereby the St. Andrew's Co-operative Company, located at St. Andrew's, about eight miles from Antigonish, will pay a certain portion of the patronage dividends, that is the profits returned to their members, to St. Martha's Hospital at Antigonish and in return the hospital will provide the shareholders and their families with free ward service for an aggregate of five weeks in any one year, free ordinary medicine and free laboratory serv-

ice. Patients desiring private rooms would receive them at half the regular rates, and the same 50 per cent reduction will apply to x-ray service and operating room charges. For this service the co-operative will pay the hospital on behalf of its shareholders — some 180 in number — the sum of \$9.00 per annum per shareholder. Medical care, as in most plans of group hospitalization, will not be included, but will be a matter of arrangement with the family doctor. He, of course, will benefit indirectly by the elimination of the hospital account. The St. Andrew's Co-operative is in a district which, including six or seven nearby villages, has a population of some 1,200.

Hospitals and provincial hospital associations have requested the Canadian Hospital Council to make application on their behalf to Ottawa, that the Farmers' Creditors Arrangement Act be so amended as to exempt debts due to hospitals, by patients, from the provisions of this Act. If this be not possible, the hospitals have indicated their strong desire that, at least, they be placed in a more favoured or secured position than they are at the present time. Acting on these requests, the Canadian Hospital Council took this matter up with the Minister of Finance, and . . . it is gratifying to know that the Government at Ottawa is taking a sympathetic view of the situation of our hospitals.

#### Group Makes Study of Old Age

A group of business and medical men set the Ontario Geriatrics Research Society into action recently with a project designed to relieve the problems of the aging. President of the Society is Harold S. Shannon; and Dr. W. W. Priddle, consultant in geriatrics for the Department of Public Welfare, is chairman of its medical advisory board. The society is faced with six major problems in its program of assistance to the aged: organic diseases, psychological problems, physical restoration and rehabilitation, nutrition and diet, employment and care.

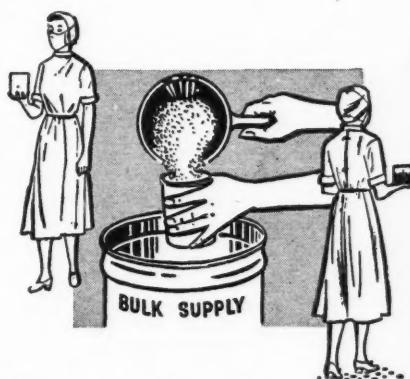
#### Women's Institute Furnishes Hospital Ward

The fine work done by Women's Institutes is exemplified in the announcement that 12 branches of the Women's Institute in the district have joined together to furnish a room at the Wingham General Hospital, Wingham, Ontario. Recently a cheque for \$800 was presented for this purpose. The door of the new ward will bear a suitable plaque, and the room will be known as the Women's Institute ward.

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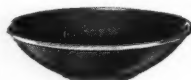
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### Understanding People

One of the bases of social sense in business or private life is an understanding of people. There are few gifts that one person can give to another as rich as understanding, and there are few necessities so vital.

We cannot imagine two departmental managers working successfully at arm's length on a project, particularly if they are highly creative people whose self-expression through their work means more to them than bread-and-butter. They need to know each other's nature, desires and interests, so as to win and give a sympathetic response to overtures and suggestions.

It can be vastly perplexing if, when we are engaged on work that requires co-operation and joint action, we come up against a personality we have not studied.

In a special issue of the *American Journal of Sociology* a few years ago, devoted to a study of "Misunderstandings in Human Relations", attention was drawn to the tendency of introverted (contemplative) and extroverted (activistic) personalities to misinterpret each other because they are unable to understand that they see different meanings and objectives in life.

Social sense in a situation like this does not consist in ignoring differences, but in getting to understand them. Study may be needed, reading a book or two, perhaps talking with a psychologist or a psychiatrist, but certainly a frank talking it out with the men concerned would help. — *The Royal Bank of Canada, Monthly Letter, July 1955.*

### Ontario Dietitians Meet

The Ontario Dietetic Association held its first annual meeting in Guelph last month when Florence Silverlock of Toronto Western Hospital was elected president. The vice-president is Dorothy Tyers, Toronto Board of Education, and the corresponding secretary, Lois Hurst of the Hospital for Sick Children, Toronto.

### "Other Articles of Regimen"

For the Art of Medicine would not have been invented at first, nor would it have been made a subject of investigation . . . if when men are indisposed, the same food and other articles of regimen which they eat and drink in good health were proper for them and if no others were preferable to these. — *Hippocrates.*

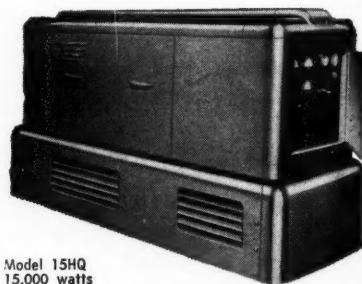
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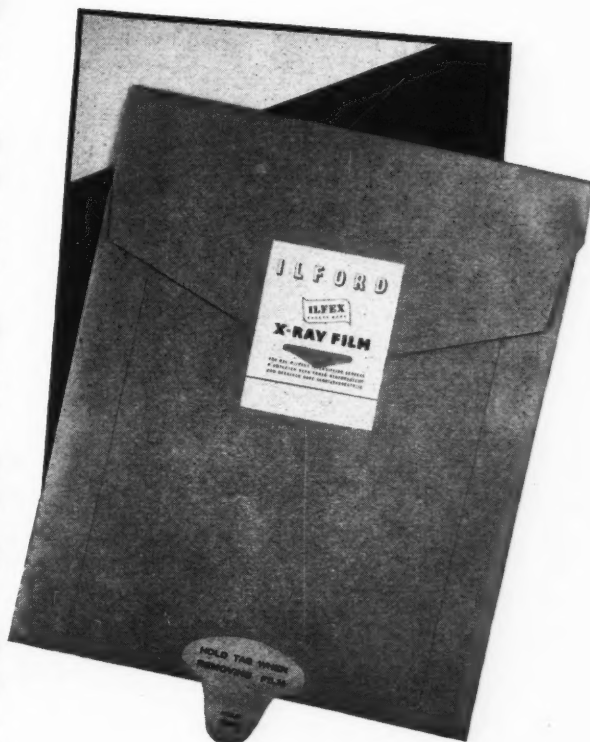
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### Disaster Institute (Concluded from page 49)

proposals and to make suggestions. Some delegates considered there was considerable merit in having communications set out in the disaster manual as a separate section, where all information relating to this topic would be available for ready reference. The institute recommended that governmental assistance in storing certain supplies within the hospital, such as burn dressings and plasma expanders, would aid any hospital that has to meet a disaster situation on short notice.

While each hospital must develop its own plan to suit its own particular needs, there are many basic principles which are common to all good hospital disaster plans. There now exist a number of excellent plans for large and small hospitals, worked out in connection with disaster institutes previously held in Canada. It was recommended that this material be used for the development of a hospital disaster planning manual which would outline basic principles to assist hospitals in the preparation of their own disaster plans. The delegates expressed a desire, also, to have the individual hospital's legal responsibility clarified as it relates to certain phases of disaster planning, particularly evacuation.

The delegates expressed their thanks to Mr. Buckner, the board of governors, and staff of the Metropolitan General Hospital for the excellent arrangements made for the meeting, for the opportunity afforded of touring the new wing, and of witnessing

the hospital's plan for the reception of casualties in action. There was definite agreement among the delegates that disaster institutes are of inestimable value for the stimulation and clarification of points in many essential areas.

The Windsor disaster institute followed the general pattern which had been developed at previous institutes. These have been held in Victoria, B.C., Halifax, N.S., Hamilton, Ont., Montreal, P.Q., and Toronto.\* Similar institutes are still to be held, under federal sponsorship for hospitals of the prairie provinces. Much of the success of the Windsor institute was due to good organization by Dr. Charron and his associates, to the careful preparation of plans by Mr. Buckner and his hospital associates, and by Miss Tillett and Dr. Nicklin. — W.D.P.

#### Earlier Institutes

\*"Preparation for Disaster is Just Common Sense", *The Canadian Hospital*, June, 1954, page 50; "Civil Defence Study in Central Ontario," *The Canadian Hospital*, January, 1955, page 42; "Montreal Disaster Institute", *The Canadian Hospital*, March, 1955, page 42; "A Disaster Plan is Well Worth the Effort," *The Canadian Hospital*, January, 1956, page 31.

#### Friendly Eyes

If I have learned anything it is that pity is more intelligent than hatred, that mercy is better even than justice, that if one walks around the world with friendly eyes one makes good friends. — Philip Gibbs.

#### Director of Nursing Education Required

Prince County Hospital, Summerside, P.E.I. requests applications for position of Director of Nursing Education and Nursing Service. A fully accredited voluntary general hospital, 116 beds, and School of Nursing, 36 students. To act as assistant to administrator, teach science subjects and plan curriculum. Degree desirable but not a requirement. Several years supervising and/or instructor experience is required in lieu of degree. Salary to be mutually agreed upon. Private living quarters in new residence. Assistant Instructress and diploma supervisors to assist in clinical teaching. Apply to: Administrator, Prince County Hospital, Summerside, P.E.I.

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### Dietitians Wanted

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### Nursing Arts Instructor

Applications are invited for the above position at the South Waterloo Memorial Hospital, Galt, Ontario. 220 beds—41 bassinets—School of Nursing—Hospital opened September 1953. Salary scale \$270. to \$300. Necessary qualifications essential. Apply Director of Nursing.

### Assistant Director of Nursing

Applications are invited for the above position at the South Waterloo Memorial Hospital, Galt, Ontario. 220 beds—41 bassinets—School of Nursing—Hospital opened September 1953. Starting salary \$300. per month. Apply Director of Nursing.

### Position Wanted

Accountant-office manager, experience in 85-bed hospital, requires position in hospital of similar or larger size: Apply Box 1013M, The Canadian Hospital, 57 Bloor St. West, Toronto, Ontario.

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### Assistant Housekeeper Required

Toronto Hospital of approximately 900 beds, requires Assistant Housekeeper. Capable of teaching and supervising staff. Apply to Box 604T, The Canadian Hospital, 57 Bloor Street, West, Toronto, Ont.

### Queensway General Hospital Toronto 14, Ont.

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### Assistant Director Required

Applications for Assistant Director will be considered. 400-bed hospital expanding to 650 beds. Applicant must be qualified in hospital administration. Apply to Secretary, Board of Commissioners, Saint John General Hospital, Saint John, N.B.

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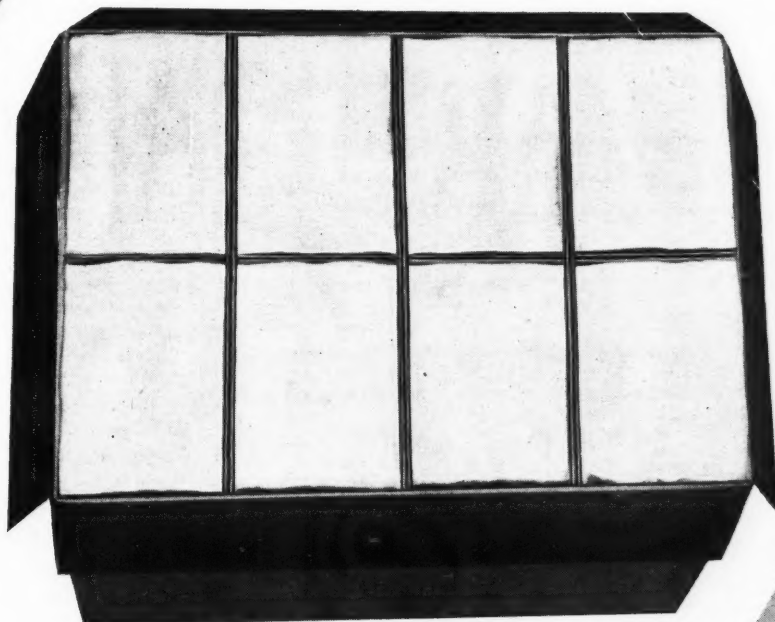
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### Espresso Wrist

A coffee-bar epidemic, which may have social-medical aspects, and which certainly has introduced an interesting orthopaedic complication, has been sweeping tea-drinking London since the end of the war, according to British physician, Dr. A. W. Lipmann Kessel.\*

Chief engineer of the epidemic is the espresso-machine operator and he is now subject to a disease formerly seen in young mothers engaged in diaper-wringing, overworked seamstresses, and high speed obsessional typists—inflamed tendons of the wrist.

For each cup of coffee, Dr. Kessel explains, the operator of an espresso machine has to carry out three to four strong movements of the wrist, and in an average day may carry out several thousand similar manoeuvres. "Barmaids are no doubt immune because the beer is pulled with wrists held stiffly, the elbow being flexed," Dr. Kessel writes. "Espresso wrist," fortunately, is not too serious a matter; it responds quickly to hydrocortisone injections and a slight change of technique. Nevertheless, the appearance of the ailment tends to reinforce the position of the

British tea-drinking population. — *Trends*.

\*Kessel, A. W. L., *The Lancet*, 6911:288 (Feb. 11) 1956.

### One Role of Architects

The safety of workers engaged on the construction and on the maintenance of building and civil engineering works deserves serious and detailed thought right from the initial stages of each project. Architects and engineers engaged on the design of works should familiarize themselves with safety rules and legislation, and with the practical details of safe working practices during construction operations. They should make it clear to their clients that the safe way is the only way in which construction work should be carried out and that financial provisions for safety precautions should be regarded as an integral element in the cost of the job.

They could also contribute to a reduction of accidents by bearing in mind, in drawing up plans, the safety, not only of construction workers, but also of maintenance men.—*ILO News*.

### Chronic Glaucoma Decreasing

Hope that chronic glaucoma may become extinct within the next 15 years was expressed by Dr. Peter C. Kronfeld, Professor of Ophthalmology at the University of Illinois College of Medicine, in an address at the annual conference in Chicago of the National Society for the Prevention of Blindness.

"Since the incidence of the disease is only about one in every 50 individuals of 40 years or over" he said, "and since its subjective manifestations are so very subtle at first, the case finding is a difficult, costly, time-consuming job. Still, progress is being made by soliciting the co-operation of the medical, optometric, nursing, and vision-testing professions, through the use of new screening instruments and through the development of new, simpler, and at the same time more definitive diagnostic methods". — *Scope*, May 2, 1956.

### Guild of Ex-Patients and Friends of Guy's

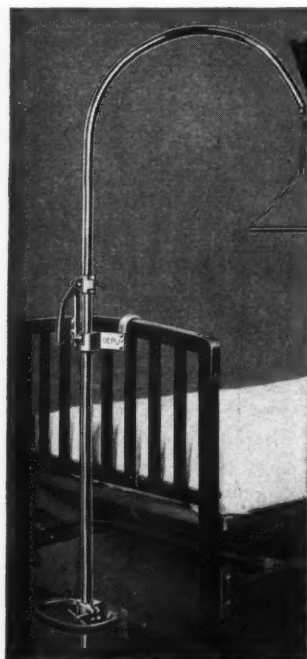
A report for 1955 indicates that the Guild of Ex-Patients and Friends of Guy's Hospital in London, Eng., had an income of over £4,200 last year. Among other gifts to patients and the hospital was a television set for the midwifery nurses and 65 upholstered settees for hospital waiting rooms. Services which the guild continues successfully include: picture distribution, patients' and nurses' libraries, window boxes around the hospital and on ward balconies, Christmas gifts, and tropical fish for the aquarium in the children's ward.

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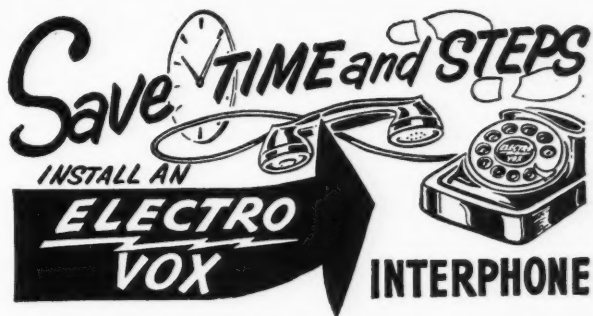
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## ... Across the Desk

*News Released by Hospital Supply Houses*

**By C.A.E.**

### **IBM Processing Centre**

A Data Processing Centre is to be established in the near future by International Business Machines Company Limited at their Head Office, Don Mills Road, Toronto. The Centre will be available for all types of scientific, engineering, accounting and statistical applications from the largest to the smallest groups, including the individual scientist.

In addition to a complete line of IBM Electric Accounting Machines, the Centre will be equipped with a Type 650 Magnetic Drum Data Processing Machine. This type of machine, sometimes known as an "electric brain", because of its large capacity magnetic memory and its ability to check the accuracy of its answers, has been produced in Canada since the beginning of 1956. It embodies a magnetic drum "memory" only four inches in diameter and sixteen inches long which spins at the rate of 12,500 revolutions a minute to make any of its 20,000 digits in "memory" available in less than three-thousandths of a second. The 650 can do sixty multiplications of ten digit numbers a second, 200 additions or subtractions per second, or fifty divisions a second.

The Centre's staff will include personnel highly trained and skilled in the application of electric and electronic computing and accounting equipment to the diversified demands of Canadian business.

### **ASR Names Personna of Canada Agents for Surgical Blades**

The Personna Blade Company of Canada, Limited, has been appointed exclusive Canadian agent for the distribution of ASR surgical blades and handles, it has been announced by Mr. Jack Hendler, Personna vice-president.

Mr. Hendler pointed out that all

ASR surgical blades are electronically tested for sharpness on a Sharpometer, a unique instrument used only by ASR.

The blades are available in foil-wrapped packages of six, as well as in the new ASR Clip-Sharp package which eliminates the necessity of unwrapping blades or the need for special racks for sterilization. Orders, placed with Personna, Hendler said, will be shipped immediately from warehouse stocks in Montreal.

### **Unconditionally Guaranteed Rubber Sheeting**

Industrial Textiles Limited are introducing a new rubberized heavy-weight double coated hospital sheeting. Boilable — .020 thickness, this hospital sheeting for mattress protection is guaranteed to comply with all the requirements of CS TS-3551A as issued by the National Bureau of Standards and Specification ZZ-S311A.

Guaranteed against damage by urine, blood, alcohol, perspiration, medication and glycerine. Colours: maroon or white. 36-in. wide, continuous rolls of 12 or 25 yards.

Write for samples to Industrial Textiles Limited, 4 Ellerbeck Street, Toronto 6.

### **Carbide's Sorbic Protects Cakes From Mold Spoilage**

Sorbic, the selective food fungistat that has gained such wide acceptance in protecting cheese, fresh fruit salads, and potato salads, has now established itself as a valuable new mold inhibitor for cakes, according to an announcement by Carbide Chemicals Company, a Division of Union Carbide Canada Limited. In a recent series of experiments on the control of molds in cakes, conducted by The Best Foods,

Inc., and Drake Bakeries, Inc., Sorbic was found to be four times as effective as commonly used commercial inhibitors. In addition Sorbic did not affect aroma, taste, volume, grain or texture.

Specifically, 9 to 13 days passed before 1 to 4 per cent of the Sorbic-protected slices were moldy. These results compare with 7 to 9 days before 2 to 6 per cent of the slices protected with a competitive inhibitor were moldy and 5 days before 2 per cent of the unprotected slices were moldy. The quantity of Sorbic added to the white batter before baking was 0.075 per cent and to the chocolate 0.122 per cent. The quantity of competitive inhibitor was 0.150 per cent to the white batter and 0.244 to the chocolate. The control contained no inhibitor.

### **Onan Issue 1956 Electric Plant Catalogue**

A new 8-page 3-color catalogue describing the complete line of Onan electric generating plans has just been released.

This new well-illustrated catalogue has been carefully designed to make it easy for the reader to select the proper type of generating plant and necessary accessories for his particular needs with a minimum of effort. Laid out in simple two-page spreads each separate series of Onan Electric Plants . . . 1-cylinder air-cooled models; 2-cylinder air-cooled models; 4, 6 and 8-cylinder water-cooled models and air-cooled Diesel models . . . are listed in complete detail.

For example one spread shows the entire range of single-cylinder air-cooled gasoline-driven Onan Electric Plants in alternating and direct current models with both the size of the unit and the starting method listed.

Below each photo spread is a detailed "Model Selection Guide" giving model number, description, starting method type of engine and dimensions and weights of each plant. Optional accessories available for the units listed on each spread are described and pictured. Individual specification sheets for all models and information on Onan's new exclusive VACU-FLO cooling system are listed as being available.

This new 1956 Onan electric plant catalogue is available without charge by writing to the manufacturer, D. W. Onan & Sons, Inc., 1434 St. Catherine St. West, Montreal, P.Q.

### **New McGlashan Silverware Catalogue**

A new hotel and hospital catalog that lists the most complete range of  
(Concluded on page 116)



UNRETOUCHED PHOTOGRAPH

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LIMITED MONTREAL

<sup>\*</sup>Trade Mark

Made in Canada

JUNE, 1956

115

### Across the Desk (Concluded from page 114)

silverware and cutlery and stainless steelware available for institutional use has just been published by McGlashan Silverware Limited, Ottawa.

Featured in this new catalog are new patterns "Strata" and "Economy" in high quality stainless steel.

Copies may be obtained by writing to the Company, Post Office Box 408, Ottawa.

### G. H. Wood Distributes Teepol Liquid Detergent

Announcement was recently made by Geoffrey H. Wood, President and General Manager of G. H. Wood &



Company Limited, of their appointment by the Shell Oil Company of Canada, Limited, as exclusive distributors in Canada for "TEEPOL" — Shell's world famous detergent, wetting agent and penetrant.

Mr. A. W. Hutchison, Shell's chemical division manager, says: "The G. H. Wood Company was chosen for this important franchise because they have Canada-wide distribution coverage, branches in most centres, as well as excellent research and laboratory facilities. It is believed that many of Wood's more than 50,000 customers will be interested in learning how 'TEEPOL' could fit into their cleaning or processing plans".

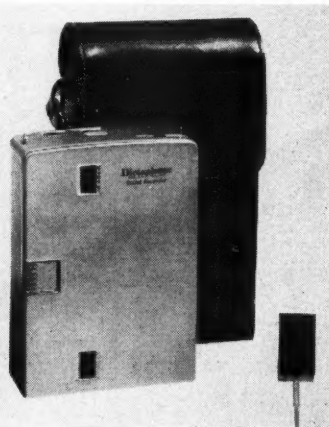
"TEEPOL" is very effective as a general service cleaner for floors, walls, windows, equipment and, in fact, on anything washable. Hospitals, schools, commercial buildings and hotels are finding it a definite boon. It cleanses faster, rinses easier and quicker and leaves the surface sparkling clean.

### Dictaphone Battery-Powered Miniature Recorder

To meet a truly modern business communications need, Dictaphone Cor-

poration introduces the Dictaphone Dictet portable tape recorder.

Offered to all those whose voice recording needs travel with them, the Dictet is a battery-operated, sub-miniature instrument weighing less than three pounds. About the size of a candid camera, the Dictet provides a full hour's recording time on re-usable magnetic tape and accompanies the travel-



ler in a trim, shoulder-slung leather case.

Ideal for use at home, in various departments in the hospital, in cars, trains and airplanes, the Dictet is also perfectly applicable in libraries, in hotel rooms, and anywhere outdoors.

A single finger-tip lever controls record, re-wind and playback. Tiny dials control volume of voice input and playback. Tapes are magazine-loaded and are mailable in special cartons for transcription or playback at their destination. By attachment of accessories, the Dictet recorder becomes a transcriber with listening device and a toe-pedal to control start-stop of playback.

Incorporating the latest technological advances in metallurgy and electronics, the Dictet is made largely of magnesium and features a completely transistorized amplifier.

### New McClary Dish Truck

A compact dish truck has been added to the McClary line of quality commercial kitchen equipment. Perfect for



use in cafeterias, restaurants and institutions of every size the McClary Super Dish Truck moves easily on rubber tired casters. Compact 41" x 20" x 40" high it is sturdily constructed with chrome plated steel tube and stainless steel shelves. It can be ordered with or without plastic or stainless steel dish basket 12" x 18" x 6" from the Kitchen Equipment Division of General Steel Wares Limited, 199 River St., Toronto.

### Shampaine Adds Modular Bassinets Line

Starting with a basic one-shelf unit Shampaine Company's new bassinet "Multi-Line" includes nineteen self contained "isolation" models.

The "Multi-Line" was developed as the result of a recent widespread survey of hospital nurseries and reflects expressed suggestions from nursery supervisors for a versatile line of bassinets that are both sturdy and at-



tractive; varied to meet individual hospital budgetary requirements and to accommodate individual nursery layout and administrative practices.

Variations include single or double storage compartments for infants' clothing, bedding, bath and medical supplies. Double compartments contain a shelf. Compartments are either open or enclosed by doors. All models may be purchased with a drop leaf shelf complete with guard-rail for bathing and dressing. A second modification offers a drawer opening from either the side or the end of the bassinet, while in yet another style all models are provided with a telescoping shelf with plastic-covered top and guard rail.

The simple modern design is executed in tubular steel, finished in white enamel or a choice of nursery enamel colours including pale blue, shell pink or silverlux. Baskets, optional at extra cost, are plastic slatted steel, or a light weight steel rod basket finished in bright cadmium plate.

Further details available from Shampaine Company, St. Louis 4, Mo.

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